near th i maner	ar bystoms Threfre Regional In	LACTI OTOTEM	TIT LI CO	1 01 1 01 11 0110 2002 1
This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fail	ilure to report can re	sult in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	g deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 03-31-2022
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-0064		Worksheet S
AND SETTLEMENT	SUMMARY			
			To 07/15/2019	Date/Time Prepared: 12/18/2019 2:44 pm
PART I - COST	REPORT STATUS			•
Provi der	1. [ X ] Electronically filed cost report		Date: 12/18/20	019 Time: 2:44 pr
use only	2. [ ] Manually submitted cost report			
	3. [ O ] If this is an amended report enter the number 4. [ F ] Medicare Utilization. Enter "F" for full or "		resubmitted this c	ost report
Contractor use only	5. [ 1 ]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [ N ] Initial Report for (3) Settled with Audit 9. [ N ] Final Report for (4) Reopened (5) Amended	11 or this Provider CCN 12		or Code: 4 olumn 1 is 4: Enter nes reopened = 0-9.

## PART II - CERTIFICATION

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by FAYETTE REGIONAL HEALTH SYSTEM (15-0064) for the cost reporting period beginning 10/01/2018 and ending 07/15/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned	1)
	Officer or Administrator of Provider(s)
	Title
	Date

			Title	XVIII			
Cost Ce	nter Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - SE	TTLEMENT SUMMARY						
1.00 Hospi tal		0	293, 499	7, 968	0	145, 424	1.00
2.00 Subprovider -	I PF	0	0	0		0	2.00
3.00 Subprovider -	IRF	0	0	0		0	3.00
4.00 SUBPROVIDER I							4. 00
5.00   Swing bed - S	NF	0	0	0		0	5. 00
6.00   Swing bed - N	F	0				0	6.00
9.00 HOME HEALTH A	GENCY I	0	0	0		0	9. 00
200. 00 Total		0	293, 499	7, 968	0	145, 424	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0064 Peri od: Worksheet S-2 From 10/01/2018 To 07/15/2019 Part I Date/Time Prepared: 12/18/2019 2:44 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1941 VIRGINIA AVE 1.00 PO Box: 1.00 Ci ty: CONNERSVI LLE State: IN 2.00 Zi p Code: 47331 County: FAYETTE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 FAYETTE REGIONAL HEALTH 150064 99915 07/01/1966 N 0 3.00 SYSTEM Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF Р Р FAYETTE REGIONAL HEALTH 15U064 99915 06/25/2009 N 7.00 7 00 SYSTEM 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1 00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 10/01/2018 07/15/2019 20.00 21.00 Type of Control (see instructions) 21.00 2 1.00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost

	reporting period? In column 2, enter "Y" for yes or	"N" for no	).					
		In-State	In-State	Out-of	Out-of	Medi cai d	Other	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		pai d days	eligible	Medi cai d	Medi cai d		days	
			unpai d	pai d days	eligible			
			days		unpai d			
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00	If this provider is an IPPS hospital, enter the	497	0	0	0	592	0	24.00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							

	Financial Systems FAYETTE REGI TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provi der CC	CN: 15-0064	Peri	od:		Work	sheet	//S-2552 S-2
					From To	n 10/0 07/1	1/2018 5/2019	Date	/Ti me	Prepare
	M	n-State edicaid aid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Medi elig unp	ate caid ible aid	Medic HMO d	ai d ays	Other Medicai days	id
. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	1.00	2.00	3.00	4.	00	5. 0	0 0	6. 00	25
	Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.									
					Uı	rban/R 1. 0			of Geo 2.00	ogr
. 00	Enter your standard geographic classification (not wage cost reporting period. Enter "1" for urban or "2" for r		at the be	ginning of	the		2	2		26
. 00	Enter your standard geographic classification (not wage reporting period. Enter in column 1, "1" for urban or "enter the effective date of the geographic reclassification.	e) status '2" for r	ural. If a		st		2	2		27
. 00	If this is a sole community hospital (SCH), enter the reffect in the cost reporting period.			CH status i			(			35
						Begi nr 1. 0			ndi ng: 2. 00	
. 00	Enter applicable beginning and ending dates of SCH state of periods in excess of one and enter subsequent dates.		cript line	36 for num	ber					36
. 00	If this is a Medicare dependent hospital (MDH), enter tis in effect in the cost reporting period.	the numbe	r of perio	ds MDH stat	us		(			37
. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)									37
. 00	If line 37 is 1, enter the beginning and ending dates of greater than 1, subscript this line for the number of penter subsequent dates.									38
						Y/ 1. 0			Y/N 2. 00	
. 00	Does this facility qualify for the inpatient hospital phospitals in accordance with 42 CFR §412.101(b)(2)(i), 1 "Y" for yes or "N" for no. Does the facility meet the accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii) or "N" for no. (see instructions)	(ii), or mileage	(iii)? En requireme	ter in colu nts in	mn	Y			Y	39
. 00	Is this hospital subject to the HAC program reduction a "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. (	1. Ente	r "Y" for			N			Y	40
							1. 0	0 2.0		
	Prospective Payment System (PPS)-Capital	£1!		Ab !						
	Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment except	tion for	extraordi n	ary circums	tance	S	N N	N N		
. 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS cap	oital? E	nter "Y fo	r yes or "N	" for	Ü	N	N		
. 00	Is the facility electing full federal capital payment? Teaching Hospitals Is this a hospital involved in training residents in a					r yes	N		N	48 56
. 00	or "N" for no.  If line 56 is yes, is this the first cost reporting per GME programs trained at this facility? Enter "Y" for y						1			57
	is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "Y", "N", complete Wkst. D, Parts III & IV and D-2, Pt. II,	complet	e Workshee				"			
	If line 56 is yes, did this facility elect cost reimbur defined in CMS Pub. 15-1, chapter 21, §2148? If yes, co	rsement f omplete W	or physici kst. D-5.		es as		A.			58
. 00	Are costs claimed on line 100 of Worksheet A? If yes,	compi ete	WKSL. D-2	, Pt. I. NAHE 413.8 Y/N	85 \	Norksh Li ne		Qual i	-Throu ficati terior Code	on
	Are you claiming nursing and allied health education (M	14115		1. 00 N		2. (	00		3. 00	60

### MOSPITAL MPD MOSPITAL HEATTH CARE COMPLEX IDENTIFICATION DATA    Provider COX. 15-0044   Provider IOV/1/2019   Provider IOV/1/2019   Provider COX. 15-0044   Provider IOV/1/2019   Provider COX. 15-0044   Provider COX. 1			HEALTH SYSTE	М	In Lie	u of Form CMS-2	2552-10
61.00   Did your hospital receive FTE slots under ACA   1.00   2.00   3.00   4.00   5.00   61.00   5.002   61.00   5.002   61.00   5.002   61.00   61.01   61.01   61.01   61.01   61.02   61.	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der (		From 10/01/2018	Part I Date/Time Prep	
Section 55037 Enter "Y for yes or "N" for no in column 1. (see Instructions)   Section 55037 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (See Section 10, 2000		Y/N	I ME	Direct GME	I ME		44 рш
Section 55037 Enter "Y for yes or "N" for no in column 1. (see Instructions)   Section 55037 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (See Section 10, 2000		1.00	2. 00	3.00	4. 00	5. 00	
61.01 enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submit ted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding 05/67M), general surgery FTEs, and per instructions) 61.03 Enter the current year total unweighted primary care FTE count (excluding 05/67M), general surgery FTEs, and per instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compiliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery all logatific and/or osteopathic FTEs in the current cost reporting period. (see instructions) 61.05 Enter the difference between the basel in eprimary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line of 1.04 minus line 61.03). (see instructions) being continuous primary care or general surgery. (see instructions) being care or general surgery. (see instructions) 61.06 End of cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 61.06 End of cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 61.06 End of cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 61.06 End of cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 61.06 End of cap relief in column 2, the program code. Enter in column 2, the program code. Enter in column 3, the IME FTE count in column 4, the direct GME FTE count in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in co							61.00
61.02 Enter the current year total unweighted primary care FTE count (excluding 08/20%), general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery all opathic and/or osteopathic FTEs in the current cost reporting period. (see instructions) 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Inter the amount of ACA 5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 61.10 Of the FTEs in line 61.05, specify each new program year or general surgery. (see instructions) 61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program name. Enter in column 2, the program name. Enter in column 3, the line 61.05, specify each expanded program specialty. If any, and the number of FTE residents for each new program name. Enter in column 4, the direct GME FTE unweighted count. There in column 4, the direct GME FTE unweighted count.  ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital related the first or seed of the program special structions of FTE exidents that rotated from a Teaching Health Center (THC) into your hospital column in this program period of HRSA THC program. (see instructions)  63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Program for the period of HRSA THC program. (see instructions)  1 Unweighted Unweighted Count.  1 Unweighted Unweighted Count.  1	column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports						61.01
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or surgery all opathic and/or osteopathic FTEs in the current cost reporting period (see instructions) 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03) (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  Program Name Program Code Unweighted Direct GME FTE Count (if any or general surgery. (see instructions)  Program Name Program Code Unweighted Direct GME FTE Count (if any or general surgery. (see instructions)  1.00 2.00 3.00 0.00 61.10  61.10 Of the FTEs in line 61.05, specify each new program specialty. If any, and the number of FTE residents for each new program. (see instructions) Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the IME FTE unweighted count. Enter in column 4, the IME FTE unweighted count. Enter in column 4, the IME FTE unweighted count. Enter in column 4, the IME FTE unweighted count. Enter in column 4, the IME FTE unweighted count. Enter in column 4, the IME FTE unweighted count. Enter in column 4, the IME FTE unweighted count. Enter in column 4, the IME FTE unweighted count. Enter in column 4, the IME FTE unweighted count. Enter in column 6, the IME FTE unweighted count in the Social See Instructions)  ACA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of	61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61. 02
surgery all lopathic and/or osteopathic FTES in the current cost reporting period. (see instructions).  61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)  61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  Program Name  Program Code Unweighted IME FTE Count of Ime	61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.03
61.05 Enter the difference between the baseline primary analor general surgery FTEs and the current year's primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see Instructions)  61.06 Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see Instructions)  Program Name  Program Code  Ilmweighted IME FTE Count  II.00  On the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count.  Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program, and the number of FTE residents for each expanded program, (see instructions) Enter in column 1, the program name. Enter in column 4, the direct GME FTE unweighted count.  ACA Provisions Affecting the Health Resources and Services Administration (HRSA)  ACA Provisions Affecting the Health Resources and Services Administration of the column 1, the unweighted count.  ACA Provisions Affecting the Health Resources and Services Administration of the column 2, the program code. Enter in column 4, the direct GME FTE unweighted count.  ACA Provisions Affecting the Health Resources and Services Administration of the column 2, the program code in this cost reporting period for which your hospital received HRSA PCRE funding (see Instructions)  1.00  ACA Provisions Affecting the Health Resources and Services Administration of the column 2, the program code in this cost reporting period for which your hospital received HRSA PCRE funding (see Instructions)  1.00  Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital column 2, the program code in this cost reporting period for which your hospital peri	61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61. 04
61.06 Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)  Program Name Program Code  Inter FTE Count  1.00 2.00 3.00 4.00  61.10  Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program specialty, if any, and the number of FTE unweighted count.  61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program odd. Enter in column 4, the direct GME FTE unweighted count.  61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count.  ACA Provisions Affecting the Health Resources and Services Administration (HRSA)  62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)  62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital O.00 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital Direct GME FTE Inter the number of FTE residents in Nonprovider Settings  63.00 Has your facility trained residents in Nonprovider Settings during this cost reporting period? Enter PY" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see Instructions)  Inweighted  Unweighted  Unw	61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.05
61. 10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program ane. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 1, the program name. Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  ACA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)  Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital one of the porting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings  Has your facility trained residents in nonprovider settings during this cost reporting period? Enter New Torpes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.06
61.10 of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the program name. Enter in column 4, the program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  ACA Provisions Affecting the Health Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)  62.00 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 Uning in this cost reporting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings  63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N  63.00 Unweighted Unweighted Unweighted Ratio (col.)		Prog	gram Name	Program Code		Direct GME	
special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  61.20 Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.  ACA Provisions Affecting the Heal th Resources and Services Administration (HRSA)  Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)  Enter the number of FTE residents that rotated from a Teaching Heal th Center (THC) into your hospital  O.00 62.00  Enter the number of FTE residents that rotated from a Teaching Heal th Center (THC) into your hospital  O.00 62.01  Enter the number of FTE residents that rotated from a Teaching Heal th Center (THC) into your hospital  O.00 62.01  Enter the number of FTE residents in Nonprovider Settings  O.00 63.00  Has your facility trained residents in Nonprovider settings during this cost reporting period? Enter  N 63.00  Will weighted Count.			1. 00	2.00			
program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.    ACA Provisions Affecting the Health Resources and Services Administration (HRSA)	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME				0.00	0.00	61. 10
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)  62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)  62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings  63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)  Unweighted Unweighted Ratio (col.	program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column				0.00	0.00	61. 20
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)  62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)  62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings  63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)  Unweighted Unweighted Ratio (col.	the direct GME FTE unweighted count.					1.00	
your hospital received HRSA PCRE funding (see instructions)  62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 during in this cost reporting period of HRSA THC program. (see instructions)  Teaching Hospitals that Claim Residents in Nonprovider Settings  63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N  "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)  Unweighted Unweighted Ratio (col.	the direct GME FTE unweighted count.					1.00	
Teaching Hospitals that Claim Residents in Nonprovider Settings  63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N  "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)  Unweighted Unweighted Ratio (col.	ACA Provisions Affecting the Health Resources and Se				rind for which		62 00
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted Unweighted Ratio (col.	ACA Provisions Affecting the Health Resources and Se  62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction of FTE residents that rotated from a feet of the number of FTE residents that rotated from a feet of the number of FTE residents.	trai ned cti ons) a Teachi	in this cos ng Health Ce	t reporting pe enter (THC) int		0.00	
Unweighted Unweighted Ratio (col.	ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction) Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC provides the provided of the provided Hospital state Claim Residents in Nonprovidents.	trained ctions) a Teachi gram. (s er Setti	in this cos ng Health Ce ee instructi ngs	t reporting pe enter (THC) int ons)	o your hospital	0.00	
FTES FTES in 1/(col. 1 + Nonprovider Hospital col. 2))	ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruction) 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC provides in the provided of the provided of the provided in the provid	trained ctions) a Teachi gram. (s er Setti ettings	in this cos ng Health Ce ee instructi ngs during this	et reporting per enter (THC) intons) cost reporting	o your hospital	0. 00 0. 00	62. 01

		Nonprovi der	Hospi tal	col. 2))	
		Si te			
		1. 00	2. 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost	reporti ng	
	period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0.00	0. 000000	64.00
	in the base year period, the number of unweighted non-primary care				
	resident FTEs attributable to rotations occurring in all nonprovider				
	settings. Enter in column 2 the number of unweighted non-primary care				
	resident FTEs that trained in your hospital. Enter in column 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see instructions)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0064 Peri od: Worksheet S-2 From 10/01/2018 Part I 07/15/2019 Date/Time Prepared: 12/18/2019 2:44 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + FTEs FTEs in col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if li is yes, or your facility 0.000000 65.00 0.00 0. 00 if line 63 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col. 1 + col. 2)) FTEs in FTFs Hospi tal Nonprovi der Si te 2. 00 3. 00 1 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5. 00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 70.00 N Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N"

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM	In Li	eu of Form CMS-	2552-10
	eriod: rom 10/01/201; o 07/15/201		epared:
	1 (	00 2.00 3.00	+
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	the most Nor "N" for with 42		76. 00
		1.00	-
Long Term Care Hospital PPS  80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.  81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Ente	n N	80. 00 81. 00
TEFRA Providers  85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes	or "N" for no	. N	85. 00
86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		. IN	86.00
87.00   Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
1000(u)(1)(b)(v1)? Eliter 1 for yes or N for ito.	V	XIX	
Title V and XIX Services	1.00	2. 00	
90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	Y	91.00
full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	N	93. 00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	N	94.00
applicable column.	0.00	0.00	05.00
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 00 N	95. 00 96. 00
97.00   If line 96 is "Y", enter the reduction percentage in the applicable column. 98.00   Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0. 00 Y	0. 00 Y	97. 00 98. 00
column 1 for title V, and in column 2 for title XIX.  98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.  C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	Y	Y	98. 01
title XIX.	Y	Y	98. 02
98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V and in column 2 for title VIX			
	N	N	98. 03

		1. 00	
Long Term Care Hospi tal PPS			
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for n 0.00 Is this a LTCH co-located within another hospital for part or all of the c		N N	80. (
"Y" for yes and "N" for no.	Lost reporting perrou? Enter	IN IN	01.1
TEFRA Provi ders			
Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter	"Y" for yes or "N" for no.	N	85.0
0.00 Did this facility establish a new Other subprovider (excluded unit) under	42 CFR Section		86.0
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			
1.00 Is this hospital an extended neoplastic disease care hospital classified u	under section	N	87.
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	V	XIX	
	1.00	2.00	
Title V and XIX Services	1.00	2.00	
.00 Does this facility have title V and/or XIX inpatient hospital services? En	nter "Y" for N	Υ	90.
yes or "N" for no in the applicable column.			
.00 Is this hospital reimbursed for title V and/or XIX through the cost report		Y	91.
full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N	00
.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certificati instructions) Enter "Y" for yes or "N" for no in the applicable column.	on); (see	N	92.
.00 Does this facility operate an ICF/IID facility for purposes of title V and	d XIX? Enter N	N	93.
"Y" for yes or "N" for no in the applicable column.			
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no	o in the N	N	94.
applicable column.			
.00 If line 94 is "Y", enter the reduction percentage in the applicable column	4	0.00	95.
.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.	o in the N	N	96.
.00   fline 96 is "Y", enter the reduction percentage in the applicable column	0.00	0.00	97.
.00 Does title V or XIX follow Medicare (title XVIII) for the interns and resi		Υ Υ	98.
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N"			
column 1 for title V, and in column 2 for title XIX.			
.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of cha		Y	98.
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in title XIX.	column 2 for		
.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of c	observation Y	Y	98.
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no i		'	70.
for title V, and in column 2 for title XIX.			
.03 Does title V or XIX follow Medicare (title XVIII) for a critical access ho		N	98.
reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for n	no in column 1		
for title V, and in column 2 for title XIX.  .04   Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101	l% of N	N	98.
outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for		IN IN	70.
in column 2 for title XIX.	ti ti o v, and		
.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE dis	sallowance on Y	Y	98.
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for ti	tle V, and in		
column 2 for title XIX.		.,	00
.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V	*	Y	98.
column 2 for title XIX.	, and in		
Rural Providers			
5.00 Does this hospital qualify as a CAH?	N		105.
6.00 If this facility qualifies as a CAH, has it elected the all-inclusive meth	nod of payment N		106.
for outpatient services? (see instructions)	. C 10B		107
7.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement			107.
training programs? Enter "Y" for yes or "N" for no in column 1. (see instryes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the pr			
reimbursed. If yes complete Wkst. D-2, Pt. II.	og. am 13 0031		
8.00 s this a rural hospital qualifying for an exception to the CRNA fee sched	dule? See 42 N	1	108.

Health Financial Systems FAYETTE REGIONAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CN: 15-0064 F	eriod: from 10/01/2	Wo	orksheet art I	MS-2552-10 S-2
			o 07/15/	2019 Da	ate/Time	Prepared:
	Physi cal	Occupati onal	Speech		2/18/2019 Respi rato	2:44 pm
	1. 00	2. 00	3. 00		4.00	
109.00  f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N	109.00
				$\vdash$	1. 00	$\dashv$
110.00Did this hospital participate in the Rural Community Hospita					N N	110.00
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.						
			1.00		2. 00	$\dashv$
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the FCHIP demonstration for the FCHIP demonstration prongular that apply: "A" for Ambulance services; "B" for action for tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N			111.00
				1. 00	2.00 3.	00
Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	. If column 2 nt for long t rs) based on	is "E", enter erm care (inclu the definition	in column udes	N	(	115.00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur			"N" for	N Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1			1		118.00
		Premi ums	Losses		Insurance	3
		1.00	2. 00		3. 00	
118.01 List amounts of malpractice premiums and paid losses:		386, 059	_	0	3.00	0118.0
			1.00		0.00	
118.02 Are malpractice premiums and paid losses reported in a cost	center other	than the	1.00 N		2. 00	118. 0
Administrative and General? If yes, submit supporting schedand amounts contained therein.  119.00 DO NOT USE THIS LINE  120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold	dule listing	cost centers	N		Y	119. 0
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quarters for the outpatient in the surprise of the outpatient in the surprise of the surprise of the outpatient in the surprise of the surprise of the outpatient in the surprise of the surprise of the outpatient in the surprise of the surprise of the outpatient in the surprise of the surprise of the outpatient in the surprise of the surprise of the outpatient in the surprise of the surprise of the outpatient in the surprise of the surprise of the outpatient in the surprise of the surprise of the outpatient in the surprise of the surprise of the outpatient in the outp	n column 1, "	Y" for yes or			'	120.0
Hold Harmless provision in ACA §3121 and applicable amendmen						
Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	nts? (see ins	tructions)	Y			121. 0
Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.  21.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	nts? (see ins antable devic fined in §190	tructions) es charged to 3(w)(3) of the	Y N			
Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.  21.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.  Transplant Center Information	nts? (see ins antable devic fined in §190 1 is "Y", ent	tructions) es charged to 3(w)(3) of the er in column 2				122. 00
Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.  21.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as det Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.  Transplant Center Information  25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N	tructions) es charged to 3(w)(3) of the er in column 2 " for no. If	N			122. 00
Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.  21.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as det Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information  25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 If this is a Medicare certified kidney transplant center, en	nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N	tructions) es charged to 3(w)(3) of the er in column 2 " for no. If	N			122. 0
Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.  21.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information  25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2	nts? (see ins antable device fined in §190 1 is "Y", ent or yes and "N nter the cert 2.	tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date	N			122. 0 125. 0 126. 0
Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.  21.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  22.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information  25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 27.00 If this is a Medicare certified heart transplant center, enter the column 27.00 If this is a Medicare certified heart transplant center, enter the column 27.00 If this is a Medicare certified heart transplant center, enter the column 27.00 If this is a Medicare certified heart transplant center, enter the column 27.00 If this is a Medicare certified heart transplant center, enter the column 27.00 If this is a Medicare certified heart transplant center, enter the column 27.00 If this is a Medicare certified heart transplant center, enter the column 27.00 If this is a Medicare certified heart transplant center, enter the column 27.00 If this is a Medicare certified heart transplant center, enter the column 27.00 If this is a Medicare certified heart transplant center, enter the column 27.00 If this is a Medicare certified heart transplant center the column 27.00 If this is a Medicare certified heart transplant center the column 27.00 If this is a Medicare certified heart transplant center the column 27.00 If this is a Medicare certified heart transplant center the column 27.00 If t	nts? (see ins antable device fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2.	es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date	N	<u> </u>		122. 0 125. 0 126. 0 127. 0
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Hold Harmless provision in ACA §3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no.  121.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.  122.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.  Transplant Center Information  125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.  126.00 If this is a Medicare certified kidney transplant center, entering in column 1 and termination date, if applicable, in column 2.  127.00 If this is a Medicare certified liver transplant center, entering in column 1 and termination date, if applicable, in column 2.  128.00 If this is a Medicare certified liver transplant center, entering in column 1 and termination date, if applicable, in column 2.  129.00 If this is a Medicare certified lung transplant center, entering column 1 and termination date, if applicable, in column 2.  130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2.	nts? (see ins antable device fined in §190 1 is "Y", entrolor yes and "N nter the certical ter the certical ter the certical er the certical er the certical enter the celumn 2.	es charged to 3(w)(3) of the er in column 2  "for no. If ification date fication date fication date ication date ication date irrification	N N			122. 00 125. 00 126. 00 127. 00 128. 00 129. 00 130. 00
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CCI	N: 15-0064		: 0/01/2018 7/15/2019	Worksheet S- Part I Date/Time Pr 12/18/2019 2	epared:
					1. 00	2. 00	
40.00 Are there any related organization chapter 10? Enter "Y" for yes or 'are claimed, enter in column 2 the	'N" for no in column 1. I	f yes, and home	office co	,	N		140.00
1.00	2.	00			3. 00		
If this facility is part of a cha			ugh 143 th	e name an	nd address	of the home	
office and enter the home office of 141.00 Name:	contractor name and contractor's Name:	ractor number.	Contro	ctor's Nu	ımborı		141.00
142.00 Street:	PO Box:		Contra	CLOI S NU	iiibei .		142.00
143. 00 Ci ty:	State:		Zi p Co	de:			143.00
· · ·	·						
144 00	The first test to March the set					1. 00	111 00
144.00 Are provider based physicians' cos	sts included in Worksheet	t A?				Y	144.00
					1. 00	2. 00	_
145.00  If costs for renal services are clipatient services only? Enter "Y'no, does the dialysis facility inceperiod? Enter "Y" for yes or "N"   146.00  Has the cost allocation methodologenter "Y" for yes or "N" for no incepes, enter the approval date (mm/o	for yes or "N" for no iclude Medicare utilization for no in column 2.  The graph of the prevince of the previous prev	n column 1. If on for this cost ously filed cost	column 1 i: reporting t report?		N		145. 00
						4.00	_
147.00Was there a change in the statisti	cal basis? Entar "V" for	s vos or "N" for	no			1. 00 N	147.00
48.00 Was there a change in the order of						N	148. 0
49.00 Was there a change to the simplifi				for no.		N	149.00
		Part A	Part B	Т	itle V	Title XIX	
		1.00	2. 00		3. 00	4. 00	
Does this facility contain a provious charges? Enter "Y" for yes or							
155. 00 Hospi tal	N TOT HO TOT EACH COMP	N N	N	D. (366 4	N N	N N	155. 00
56.00 Subprovi der - IPF		N	N		N	N	156. 0
57. 00 Subprovi der - I RF		N	N		N	N	157. 0
158. 00 SUBPROVI DER							158. 0
59.00 SNF  60.00 HOME HEALTH AGENCY		N I	N N		N N	N N	159. 00 160. 00
161. OO CMHC		IN IN	N		N	N N	161. 0
101.00						.,	101.00
						1. 00	
Multicampus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has c	one or more campu	uses in di	fferent C	BSAs?	N	165.00
Enter 1 for yes or in for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4.00	5. 00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. (	00 166. 00
						1.00	
Health Information Technology (HI	[) incentive in the Ameri	ican Recovery and	d Reinvest	ment Act		1. 00	
67.00 s this provider a meaningful user 68.00 of this provider is a CAH (line 10	under §1886(n)? Enter O5 is "Y") and is a meani	"Y" for yes or " ngful user (line	'N" for no	•	r the	Y	167. 00 0168. 00
reasonable cost incurred for the H 68.01 If this provider is a CAH and is a			nualify:	for a har	dshi n		168. 0°
exception under §413.70(a)(6)(ii)′ [69.00] F this provider is a meaningful of	P Enter "Y" for yes or "N user (line 167 is "Y") ar	√" for no. (see i	nstructio	ns)	·	9. (	99169.00
	nne)						1
transition factor. (see instruction	ons)			Bed	ai nni na	Endi na	
	ons)				gi nni ng 1. 00	Endi ng 2. 00	

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	NTIFICATION DATA	Provider CCN: 15-0064		Worksheet S-2	2
			From 10/01/2018		
			To 07/15/2019	Date/Time Pre	
				12/18/2019 2:	44 pm
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider h	have any days for in	dividuals enrolled in	N	C	171.00
section 1876 Medicare cost plans reporte	ed on Wkst. S-3, Pt.	I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1.	If column 1 is yes,	enter the number of secti	on		
1876 Medicare days in column 2. (see ins	structions)				

SPI T	FI NANCI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019		- epared:
				Y/N	Date	T Dill
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO re	osnoneos Ent	1.00	2. 00	
	mm/dd/yyyy format.	i ioi aii no i	esponses. Lin	ter arr dates in	the	
	COMPLETED BY ALL HOSPITALS					
00	<u>Provider Organization and Operation</u> Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c		instructions		\/ /I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.			2.0		
Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar						3.0
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports  Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	N			4.0
00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N	Legal Oper.	
	Accorded Educational Activities			1. 00	2.00	
	Approved Educational Activities  Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider i	s N		6.0
00	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see instructions.  N					
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	N N		7.0		
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.				9.0
	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.  Are GME cost directly assigned to cost centers other than I			N N		10.0
	Teaching Program on Worksheet A? If yes, see instructions.					
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 0 13. 0
	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	fyes, see in	nstructi ons.	N	14.0
	Bed Complement Did total beds available change from the prior cost reporti	na period? If	ves, see ins	structions.	Y	15.0
		Par	t A	Par		
		Y/N 1. 00	2.00	Y/N 3.00	<u>Date</u> 4. 00	
	PS&R Data					
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	Υ	08/14/2019	Y	08/14/2019	16.0
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17.0
00	in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R  Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18.0
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.0

Health Financial Systems FAYETTE REGIONAL	L HEALTH SYSTE	И	In Lie	u of Form CM	S-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019	Date/Time F 12/18/2019	repared:			
		iption	Y/N	Y/N				
20.00 If line 16 or 17 is yes, were adjustments made to PS&R		0	1.00 N	3. 00 N	20.00			
Report data for Other? Describe the other adjustments:			IN	IN IN	20.00			
noport data for other seconds the other day detimenter	Y/N	Date	Y/N	Date				
	1.00	2.00	3. 00	4. 00				
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00			
				1.00				
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)		1.00				
Capital Related Cost								
22.00 Have assets been relifed for Medicare purposes? If yes, se	e instructions	3			22. 00			
23.00 Have changes occurred in the Medicare depreciation expense	e due to apprai	sals made du	ring the cost		23. 00			
reporting period? If yes, see instructions.								
24.00 Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost r	eporting period?		24.00			
25.00 Have there been new capitalized leases entered into during	the cost repo	orting period	? If yes, see		25. 00			
instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ina period?	lf ves see		26.00			
instructions.	ine cost report	ing period.	11 yes, see		20.00			
27.00 Has the provider's capitalization policy changed during th	ne cost reporti	ng period? I	f yes, submit		27. 00			
Interest Expense								
Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting								
period? If yes, see instructions.								
.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions								
0.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see								
instructions.								
31.00 Has debt been recalled before scheduled maturity without i instructions.								
Purchased Servi ces				l				
	2.00 Have changes or new agreements occurred in patient care services furnished through contractual							
arrangements with suppliers of services? If yes, see instr					22.00			
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	pri eu pertarii	ng to compet	itive broating: ii		33.00			
Provi der-Based Physi ci ans								
34.00 Are services furnished at the provider facility under an a	rrangement wit	h provider-b	ased physicians?		34.00			
If yes, see instructions.								
35.00 If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		ents with the	provi der-based		35.00			
project and antiting the cook reporting periods. I just a			Y/N	Date				
			1. 00	2. 00				
Home Office Costs								
36.00 Were home office costs claimed on the cost report?		. h66!			36.00			
37.00 If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	e nome office	17		37.00			
38.00 If line 36 is yes , was the fiscal year end of the home of			f		38.00			
the provider? If yes, enter in column 2 the fiscal year en	nd of the home	offi ce.			20.00			
39.00 If line 36 is yes, did the provider render services to oth see instructions.	ner chain compo	onents? If ye	2S,		39. 00			
40.00 If line 36 is yes, did the provider render services to the	home office?	If yes, see			40.00			
i nstructi ons.	1							
	00							
Cost Report Preparer Contact Information		. 00	2.					
41.00 Enter the first name, last name and the title/position	TI NA		SEVERS		41.00			
held by the cost report preparer in columns 1, 2, and 3,								
respectively.	DILLE & CO. 11	^			42.00			
42.00 Enter the employer/company name of the cost report preparer.	BLUE & CO, LLO	J			42.00			
	317-713-7946		TSEVERS@BLUEAN	DCO. COM	43.00			
report preparer in columns 1 and 2, respectively.	I							

Health Financial Systems FAYETTE REGIONAL			HEALTH SYSTEM		In Lieu of Form CMS-2552-10			
HOSPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN:	15-0064	Peri od: From 10/01/2018	Worksheet S-2 Part II		
					To 07/15/2019		pared: 44 pm	
			3. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	M	ANAGER				41.00	
	held by the cost report preparer in columns 1, 2, and 3	.						
	respecti vel y.							
42.00	Enter the employer/company name of the cost report						42.00	
	preparer.							
43.00	Enter the telephone number and email address of the cos	t					43.00	
	report preparer in columns 1 and 2, respectively.							

Period: Worksheet S-3
From 10/01/2018 Part I
TO 07/15/2019 Parte/Time Propagate Health Financial Systems FAYETTE RECEDENCE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-0064

				Τ̈́	o 07/15/2019	Date/Time Prep 12/18/2019 2:	
						1/P Days /	чч рііі
						0/P Vi si ts /	
						Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00	2.00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	25	7, 200	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		25	7, 200	0.00	0	7.00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	31.00	20	5, 760	0.00	0	8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13.00
14.00	Total (see instructions)		45	12, 960	0. 00	0	14.00
15. 00	CAH visits					0	15.00
16. 00	SUBPROVIDER - I PF	40.00	0			0	16.00
17. 00	SUBPROVIDER - IRF	41.00	0			0	17.00
18. 00	SUBPROVI DER	42. 00	0	C		0	18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE	101 00					21.00
22. 00	HOME HEALTH AGENCY	101.00				0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		_	_			23. 00
24.00	HOSPI CE	116.00	0	C			24.00
24. 10	HOSPICE (non-distinct part)	30.00					24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	00.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	45			0	26. 25
27. 00	Total (sum of lines 14-26)		45				27.00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		0				31.00
32.00	Labor & delivery days (see instructions)		0	O			32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days						33. 00
	LTCH non-covered days  LTCH site neutral days and discharges						33. 00
33.01	TETOT SITE HEUTTAI days and dischalges	ı I		I	ı I		55.01

Heal th Fi nancial SystemsFAYETTE REHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA FAYETTE REGIONAL HEALTH SYSTEM Peri od: Worksheet S-3 From 10/01/2018 Part I To 07/15/2019 Date/Ti me Prepared: 12/18/2019 2:44 pm Provider CCN: 15-0064

				'	0 0,, 10, 201,	12/18/2019 2:	44 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
		.,,,-					
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		497				1.00
00	8 exclude Swing Bed, Observation Bed and	000	.,,	0, .2.			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	10	592				2.00
3.00	HMO IPF Subprovider	0	0,2				3.00
4. 00	HMO IRF Subprovider		0	1			4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF		0	1			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	٩	0				6.00
7. 00	Total Adults and Peds. (exclude observation	568	497				7.00
7.00	1	300	497	3, 421			7.00
8. 00	beds) (see instructions)	71	0	144			0 00
9. 00	INTENSIVE CARE UNIT	/ 1	U	144			8. 00 9. 00
	CORONARY CARE UNIT						
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0				13.00
14. 00	Total (see instructions)	639	497	3, 588		369. 18	ł
15. 00	CAH visits	0	0				15. 00
16. 00	SUBPROVIDER - I PF	0	0	0			1
17. 00	SUBPROVI DER - I RF	0	0	l ~			
18. 00	SUBPROVI DER		0	0	0. 00	0.00	ł
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0	0	0	0. 00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE	0	0	0	0.00	0.00	24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	369. 18	27. 00
28.00	Observation Bed Days		0	783			28. 00
29.00	Ambul ance Trips	ol					29.00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF			l o			31.00
32. 00	Labor & delivery days (see instructions)	0	0	Ö			32.00
32. 01	Total ancillary labor & delivery room		Ü	0			32. 01
52. 51	outpatient days (see instructions)			I			32.01
33. 00	LTCH non-covered days	٥					33.00
	LTCH site neutral days and discharges	0					33. 01
55. 51	12.5 5. to floati ai days and ai sondi gos	١		ı	l .	I	, 55. 51

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 10/01/2018 | Part | | To 07/15/2019 | Date/Time Prepared: Provi der CCN: 15-0064

				To	07/15/2019	Date/Time Pre 12/18/2019 2:	
		Full Time		Di sch	arges		,
		Equi val ents		I			
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	179	83	997	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			4	111		2.00
3. 00	HMO IPF Subprovider				0		3.00
4. 00	HMO I RF Subprovi der				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	179	83	997	
15.00	CAH visits						15.00
16. 00	SUBPROVIDER - IPF	0.00	0		0	0	16.00
17. 00	SUBPROVIDER - IRF	0.00	0	1	0	0	17.00
18. 00	SUBPROVI DER	0. 00	0	)	0	0	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0. 00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE	0. 00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27.00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
00.00	outpatient days (see instructions)						00.00
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33. 01

Heal th	Financial Systems	FA	YETTE REGIONAL	HEALTH SYSTEM	l	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C	CN: 15-0064 F	Period: From 10/01/2018 To 07/15/2019	Worksheet S-3 Part II	pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Sal ari es (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	SALARI ES							
1. 00	Total salaries (see	200. 00	14, 302, 291	0	14, 302, 291	784, 266. 00	18. 24	1. 00
2. 00	instructions) Non-physician anesthetist Part		0	0	(	0. 00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	0	(	0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		10, 933	0	10, 933	64. 00	170. 83	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		0 1, 849, 843	0		0. 00 3 11, 880. 00	0. 00 155. 71	4. 01 5. 00
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	C	0.00	0.00	6. 00
7. 00	Interns & residents (in an approved program)	21. 00	0	0	(	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved		0	0	(	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	C	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 1, 818, 366	0 32, 515	1, 850, 881	0. 00 1 138, 918. 00	0. 00 13. 32	
.0.00	instructions) OTHER WAGES & RELATED COSTS		., 0.0, 000	02, 0.0	1, 555, 55	100,710.00	101.02	.0.00
11. 00	Contract labor: Direct Patient Care		831, 143	0	831, 143	15, 833. 00	52. 49	11.00
12. 00	Contract Labor: Top Level management and other management and administrative		0	0	(	0.00	0. 00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		533, 955	0	533, 955	5, 340. 00	99. 99	13. 00
14. 00	Home office and/or related organization salaries and		0	0	C	0.00	0. 00	14.00
14. 01	wage-related costs Home office salaries		0	0		0.00	0. 00	14. 01
14. 02	Related organization salaries		0	0	(	0.00		
15. 00	Home office: Physician Part A - Administrative		0	0		0.00	0. 00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	(	0.00	0.00	16. 00
17. 00	Wage-related costs (core) (see		1, 144, 270	0	1, 144, 270			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)							18. 00
19.00	Excluded areas		258, 476	0	258, 476			19.00
20. 00	Non-physician anesthetist Part A Non-physician anesthetist Part		0	0				20.00
	B Physician Part A -		104	0	104	1		22. 00
22. 01	Administrative Physician Part A - Teaching		0	0				22. 01
23. 00	Physician Part B		50, 794	0	50, 794	1		23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0	0	(	)		24. 00 25. 00
25. 50	Home office wage-related (core)		0	0	C			25. 50
25. 51	Related organization wage-related (core)		0	0	C			25. 51
25. 52	Home office: Physician Part A - Administrative -		0	0				25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching -		0	0	(			25. 53
	wage-related (core)				l			

Provider CCN: 15-0064

					To	07/15/2019	Date/Time Pre 12/18/2019 2:	
		Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			·	Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst.	3)	col. 4	col. 5)	
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI							
26.00	Employee Benefits Department	4. 00	188, 715		188, 715		28. 81	26.00
27. 00	Administrative & General	5. 00	1, 682, 229	-229, 756	1, 452, 473		24. 85	
28. 00	Administrative & General under		0	0	0	0. 00	0. 00	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00	0. 00	
30.00	Operation of Plant	7. 00	267, 612	483	268, 095		21. 58	
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00	0. 00	
32.00	Housekeepi ng	9. 00	344, 158	3, 396	347, 554	45, 912. 00	7. 57	
33.00	Housekeeping under contract		0	0	0	0. 00	0. 00	33.00
	(see instructions)							
34.00	Dietary	10. 00	382, 252	-182, 312	199, 940			34.00
35. 00	Dietary under contract (see instructions)		0	0	0	0. 00	0. 00	35. 00
36.00	Cafeteri a	11. 00	0	184, 509	184, 509	13, 701. 00	13. 47	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00	0. 00	37.00
38.00	Nursing Administration	13. 00	483, 630	8, 796	492, 426	19, 816. 00	24. 85	38.00
39.00	Central Services and Supply	14.00	55, 894	395	56, 289	3, 085. 00	18. 25	39.00
40.00	Pharmacy	15. 00	237, 425	4, 338	241, 763	8, 814. 00	27. 43	40.00
41.00	Medical Records & Medical	16. 00	586, 041	38, 222	624, 263	29, 927. 00	20. 86	41.00
	Records Library							
42.00	Social Service	17. 00	0	0	0	0. 00	0. 00	42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	IEALTH SYSTEM		
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 15-0064	Peri od:	Worksheet S-3	

HOSPI	TAL WAGE INDEX INFORMATION			Provi der Ci		Period: From 10/01/2018 To 07/15/2019		
							12/18/2019 2:	44 pm
		Worksheet A	Amount	Recl assi fi cat	, ,	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		12, 452, 448	0	12, 452, 44	8 772, 386. 00	16. 12	1.00
	instructions)							
2.00	Excluded area salaries (see		1, 818, 366	32, 515	1, 850, 88	1 138, 918. 00	13. 32	2.00
	instructions)							
3.00	Subtotal salaries (line 1		10, 634, 082	-32, 515	10, 601, 56	7 633, 468. 00	16. 74	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 365, 098	0	1, 365, 09	8 21, 173. 00	64. 47	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		1, 144, 374	0	1, 144, 37	4 0.00	10. 79	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		13, 143, 554	-32, 515	13, 111, 03	9 654, 641. 00	20. 03	6.00
7.00	Total overhead cost (see		4, 227, 956	-171, 929	4, 056, 02	7 216, 689. 00	18. 72	7.00
	instructions)							

	To 07/15/20	019 Date/Time Pre 12/18/2019 2:	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	-1, 947	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	1, 500, 278	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	-68, 276	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	-43, 981	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	-82, 119	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	168, 467	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106	5. 0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	-18, 778	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (	(see 0	21.00
	instructions))	, ,	
22. 00	Day Care Cost and Allowances	0	22.00
23. 00	Tuition Reimbursement	0	23.00
24. 00	Total Wage Related cost (Sum of Lines 1 -23)	1, 453, 644	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00
		•	•

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0064	Peri od:	Worksheet S-3
		From 10/01/2018	
			D-+- /T! D

		To 07/15/2019	Date/Time Pre	
		0	12/18/2019 2:	44 pm
	Cost Center Description	Contract	Benefit Cost	
		Labor 1.00	2.00	
	PART V - Contract Labor and Benefit Cost	1.00	2.00	
	Hospital and Hospital-Based Component Identification:			-
1. 00	Total facility's contract labor and benefit cost	831, 143	1, 453, 644	1.00
2. 00	Hospi tal	831, 143		1
3. 00	Subprovi der - TPF	031, 143	1, 455, 644	3.00
4. 00	Subprovider - IRF			4.00
5. 00	Subprovider - (Other)			5.00
6. 00	Swing Beds - SNF	0	0	6.00
7. 00	Swing Beds - NF	0	0	7.00
8. 00	Hospi tal -Based SNF	0	U	8.00
9. 00	Hospi tal -Based NF			9.00
	Hospi tal -Based OLTC			10.00
	Hospi tal -Based HHA	0	0	11.00
	Separately Certified ASC		0	12.00
	Hospi tal -Based Hospi ce	0	0	13.00
	Hospital-Based Health Clinic RHC	0	U	14.00
	Hospital-Based Health Clinic FOHC			15.00
				16.00
	Hospital -Based-CMHC			17.00
	Renal Dialysis			
18.00	Other	1	0	18.00

Heal th	Financial Systems FAYETTE REGIONAL H	EALTH SYSTEM		In Lie	u of Form CMS-2	2552-10				
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15		eri od:	Worksheet S-1					
				rom 10/01/2018 o 07/15/2019		pared·				
					12/18/2019 2:					
					1. 00					
	Uncompensated and indigent care cost computation									
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 c Medicaid (see instructions for each line)	ivided by line 2	202 column	8)	0. 350867	1. 00				
2. 00	Net revenue from Medicaid				930, 671	2. 00				
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00				
4.00	If line 3 is yes, does line 2 include all DSH and/or suppleme	, ,	om Medicai	d?	0	4. 00 5. 00				
5.00										
6. 00 7. 00	Medicaid charges Medicaid cost (line 1 times line 6)				6, 391, 312 2, 242, 500	6. 00 7. 00				
8. 00	Difference between net revenue and costs for Medicaid program	(line 7 minus s	sum of line	es 2 and 5; if	1, 311, 829					
	< zero then enter zero)	<u> </u>								
0.00	Children's Health Insurance Program (CHIP) (see instructions	for each line)				0.00				
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	9. 00 10. 00				
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0					
12.00	Difference between net revenue and costs for stand-alone CHIF	(line 11 minus	line 9; it	f < zero then	0					
	enter zero)									
13. 00	Other state or local government indigent care program (see in Net revenue from state or local indigent care program (Not in			<u> </u>	0	13. 00				
14. 00	Charges for patients covered under state or local indigent ca	0	14.00							
00	10)	. o p. og. a (								
15. 00	State or local indigent care program cost (line 1 times line				0					
16. 00										
	13; if < zero then enter zero)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see									
	instructions for each line)				`					
17. 00	Private grants, donations, or endowment income restricted to	9				17.00				
18. 00 19. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loc			(sum of lines	0 1, 311, 829	18. 00 19. 00				
	8, 12 and 16)									
			i nsured	Insured	Total (col. 1					
			atients 1.00	patients 2.00	+ col . 2) 3.00					
	Uncompensated Care (see instructions for each line)		11.00	2.00	0.00					
20. 00	Charity care charges and uninsured discounts for the entire f (see instructions)	acility	102, 788	264, 181	366, 969	20.00				
21. 00	Cost of patients approved for charity care and uninsured disc	ounts (see	36, 065	264, 181	300, 246	21.00				
22. 00	instructions) Payments received from patients for amounts previously writte	n off as	0	0	0	22. 00				
	charity care		0/ 0/5	0/4 404	200 044					
23.00	Cost of charity care (line 21 minus line 22)		36, 065	264, 181	300, 246	23.00				
					1. 00 N	24. 00				
24. 00	24.00 Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit									
25. 00	imposed on patients covered by Medicaid or other indigent care program?  15.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit									
26.00										
27. 00	Medicare reimbursable bad debts for the entire hospital compl	•			94, 321	27. 00				
27. 01	· '	(see instruction	ıs)		145, 109					
28.00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt e	vnanca (con inct	ructione)		1, 713, 645 652, 049					
30.00		vhense (see 11121	1 4611 0115)		952, 295					
	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			2, 264, 124					
	·									

Health Financial Systems FA	YETTE REGIONAL	HEALTH SYSTEM		In Lieu	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co		eri od:	Worksheet A	
				rom 10/01/2018 o 07/15/2019	Date/Time Pre	narod:
				0 0//13/2019	12/18/2019 2:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
			, i	A-6)	(col. 3 +-	
				·	col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT		1, 204, 215	1, 204, 215	0	1, 204, 215	1.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT	188, 715	1, 498, 129	1, 686, 844	0	1, 686, 844	4.00
5. 00   00500 ADMINI STRATI VE & GENERAL	1, 682, 229	6, 533, 640	8, 215, 869	-229, 756	7, 986, 113	5.00
7.00   00700   OPERATION OF PLANT	267, 612	971, 077	1, 238, 689	-615, 001	623, 688	7. 00
7.01   OO701   OPERATION OF PLANT	0	0	0	615, 484	615, 484	7. 01
8.00   00800   LAUNDRY & LINEN SERVICE	0	92, 379	92, 379		92, 379	8. 00
9. 00   00900   HOUSEKEEPI NG	344, 158	79, 783			427, 337	9. 00
10. 00  01000 DI ETARY	382, 252	296, 664	678, 916		353, 407	10.00
11. 00   01100   CAFETERI A	0	0	0	,	327, 706	11.00
13.00 O1300 NURSING ADMINISTRATION	483, 630	35, 097	518, 727		527, 523	13. 00
14.00  01400   CENTRAL SERVICES & SUPPLY	55, 894	332, 404	388, 298		157, 582	14. 00
15. 00   01500   PHARMACY	237, 425	1, 719, 469			1, 961, 232	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	586, 041	83, 860	669, 901	38, 222	708, 123	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS	1, 447, 252	1, 335, 383			2, 791, 463	30.00
31. 00 03100 INTENSIVE CARE UNIT	670, 845	91, 119	761, 964	12, 250	774, 214	31.00
40. 00   04000   SUBPROVI DER -   PF	0	0	0	0	0	40.00
41. 00   04100   SUBPROVI DER -   I RF	0	0	0	0	0	41.00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42.00
43. 00   04300   NURSERY	0	0	0	17, 717	17, 717	43.00
ANCILLARY SERVICE COST CENTERS				1		
50. 00 05000 OPERATING ROOM	396, 998	355, 216			758, 930	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	611, 376	1, 274, 448			1, 890, 610	54.00
60. 00 06000 LABORATORY	455, 959	718, 017			1, 176, 582	60. 00 65. 00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	275, 405	38, 920			319, 330	•
	247, 510	24, 888	272, 398	4, 438	276, 836	66.00
69. 00   06900   ELECTROCARDI OLOGY 69. 01   06901   CARDI AC   REHAB	124 727	21 040	154 407	2 420	150 115	69. 00 69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	134, 727	21, 960	156, 687	2, 428	159, 115 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		221 111	231, 111	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		231, 111	231, 111	73.00
OUTPATIENT SERVICE COST CENTERS	ı			ıj Uj	0	73.00
91. 00 09100 EMERGENCY	961, 163	1, 154, 111	2, 115, 274	18, 772	2, 134, 046	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	701, 103	1, 154, 111	2,113,274	10, 772	2, 134, 040	92.00
93. 00   04050   CLINI C	3, 054, 734	655, 866	3, 710, 600	55, 868	3, 766, 468	93.00
93. 01   04950   BI C	0,001,701	000, 000	0, 710, 000	0	0, 700, 100	93. 01
93. 05   04954   PODI ATRY	o	0	Ö		0	93.05
OTHER REIMBURSABLE COST CENTERS	-1		<u>-</u>	-1		
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
101.00 10100 HOME HEALTH AGENCY	o	0	O	o	0	101.00
SPECIAL PURPOSE COST CENTERS				<u>'</u>		
116. 00 11600 HOSPI CE	0	0	C	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	12, 483, 925	18, 516, 645	31, 000, 570	-32, 515	30, 968, 055	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191.00
191. 01 19101 FMH DIAGNOSTIC CENTER	111, 381	23, 325	134, 706	2, 222	136, 928	191. 01
191. 02 19102 WELLNESS	57, 957	84, 269		1, 080	143, 306	191. 02
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	4, 553	4, 553	1, 232	5, 785	192. 00
192. 01 19201 RFE	0	167	167	0	167	192. 01
192. 02 19202 MARKETI NG	48, 730	21, 272	70, 002	902	70, 904	192. 02
192. 03 19203 FOUNDATI ON	0	0	C	0		192. 03
192.06 19206 HEART CENTER	0	0	0	0	0	192. 06
192. 07 19207 WVCP	1, 508, 007	1, 017, 221	2, 525, 228	27, 079	2, 552, 307	
192.08 19208 OCCUPATI ONAL MED	0	1, 126				192. 08
192. 10 19210 HOSPI TALI ST	0	453, 573	453, 573	0	453, 573	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	1			194. 00
194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS	92, 291	6, 977		I I	99, 268	
200.00   TOTAL (SUM OF LINES 118 through 199)	14, 302, 291	20, 129, 128	34, 431, 419	0	34, 431, 419	200. 00

 Health Financial
 Systems
 FAYETTE REGIONA

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0064 Peri

				12/18/2019 2:	: 44 pm
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For		
			Allocation		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-14, 894	1, 189, 321		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	1, 686, 844		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 377, 343	6, 608, 770		5. 00
7.00	00700 OPERATION OF PLANT	-600	623, 088		7. 00
7. 01	00701 OPERATION OF PLANT	0	615, 484		7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	92, 379		8. 00
9.00	00900 HOUSEKEEPI NG	0	427, 337		9. 00
10.00	01000 DI ETARY	0	353, 407		10.00
11.00	01100 CAFETERI A	-146, 293	181, 413		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	157, 582		14.00
15.00	01500 PHARMACY	-768, 169	1, 193, 063		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	-10, 829	697, 294		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS				1
30.00	03000 ADULTS & PEDI ATRI CS	-931, 629	1, 859, 834		30.00
	03100 INTENSIVE CARE UNIT	0	1		31.00
	04000 SUBPROVI DER - I PF	0	ol ol		40.00
	04100 SUBPROVI DER - I RF	0	1		41.00
	04200 SUBPROVI DER	Ö			42.00
	04300 NURSERY	Ö	1		43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS		.,,,,,,		1 .0.00
50.00	05000 OPERATING ROOM	-355, 124	403, 806		50.00
	05400 RADI OLOGY-DI AGNOSTI C	-361, 682	1		54.00
60.00	06000 LABORATORY	-115, 844			60.00
	06500 RESPI RATORY THERAPY	0			65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 000	1		66.00
	06900 ELECTROCARDI OLOGY	0,000	0		69.00
	06901 CARDI AC REHAB	Ö			69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	231, 111		72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
	OUTPATIENT SERVICE COST CENTERS	-	-1		
91. 00	09100 EMERGENCY	-1, 041, 834	1, 092, 212		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, ,			92.00
	04050 CLI NI C	-2, 486, 409	1, 280, 059		93.00
93. 01	04950 BI C	0	1		93. 01
	04954 PODI ATRY	0	1		93. 05
	OTHER REIMBURSABLE COST CENTERS		•		1
95.00	09500 AMBULANCE SERVICES	0	0		95. 00
	10100 HOME HEALTH AGENCY	0	1		101.00
	SPECIAL PURPOSE COST CENTERS				
116.00	11600 HOSPI CE	0	0		116.00
118.00		-7, 607, 650	23, 360, 405		118.00
	NONREI MBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191.00	19100 RESEARCH	0	o		191.00
	19101 FMH DIAGNOSTIC CENTER	0	136, 928		191.01
	19102 WELLNESS	0			191. 02
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	5, 785		192.00
192. 01	19201 RFE	0	167		192. 01
	19202 MARKETI NG	0	1		192.02
	19203 FOUNDATION	0	1		192. 03
	19206 HEART CENTER	Ö	1		192.06
	19207 WVCP	Ö	1		192. 07
	19208 OCCUPATI ONAL MED	0			192. 08
	19210 HOSPI TALI ST	Ö	1		192. 10
	07950 OTHER NONREI MBURSABLE COST CENTERS	Ö	1		194.00
	07951 OTHER NONREI MBURSABLE COST CENTERS	0			194. 01
200.00		-7, 607, 650			200.00
		•			-

RECLASS	SI FI CATI ONS			Provi der (	CCN: 15-0064	Peri od: From 10/01/2018	Worksheet A-6	)
						To 07/15/2019	Date/Time Pre 12/18/2019 2:	
		Increases		<b>'</b>		<b>.</b>	12, 10, 201, 2.	1 1 p
	Cost Center	Li ne #	Sal ary	0ther				
	2. 00	3. 00	4. 00	5. 00				
	A - CAFETERIA						·	

1. 00 CAFE TOTA B - 1. 00 NURS TOTA C - 1. 00 ADMI 2. 00 OPER 3. 00 HOUS 4. 00 DI ET 5. 00 NURS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 PADI 12. 00 RADI 13. 00 LABC 14. 00 RESE	NURSERY RSERY	Li ne # 3.00	Sal ary 4. 00 184, 509 184, 509	0ther 5. 00 143, 197 143, 197	1.00
1. 00 CAFE TOTA B - 1. 00 NURS TOTA C - 1. 00 ADMI 2. 00 OPER 3. 00 HOUS 4. 00 DI ET 5. 00 NURS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 OPER 12. 00 ADUL 13. 00 LABC 14. 00 RESE	CAFETERI A ETERI A ALS NURSERY ESERY ALS	11.00	184, 509	143, 197	1.00
1. 00 CAFE TOTA B - 1. 00 NURS TOTA C - 1. 00 ADMI 2. 00 OPER 3. 00 HOUS 4. 00 DI ET 5. 00 NURS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 OPER 11. 00 OPER 11. 00 RESE	ETERI A  ALS  NURSERY RSERY ALS				1.00
1. 00 NURS TOTA  B - NURS TOTA C - 1. 00 ADMI 2. 00 OPER 3. 00 HOUS 4. 00 DI ET 5. 00 NURS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 OPER 11. 00 OPER 12. 00 ADUL 13. 00 LABC 14. 00 RESE	ALS NURSERY RSERY ALS				1.00
B - NURS TOTA C	NURSERY RSERY ALS	43.00	184, 509	143, 197	
1. 00 NURS TOTA C - 1. 00 ADMI 2. 00 OPER 3. 00 HOUS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 OPER 12. 00 RADI 13. 00 LABG 14. 00 RESE	RSERY	43.00			
TOTA  C -  1. 00 ADMI 2. 00 OPER 3. 00 HOUS 5. 00 NURS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 OPER 12. 00 RADI 13. 00 LABC 14. 00 RESE	ALS	43.00			
1. 00 ADMI 2. 00 OPER 3. 00 HOUS 4. 00 DI ET 5. 00 NURS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 OPER 11. 00 RADI 12. 00 RADI 13. 00 LABO 14. 00 RESE			14, 533	3, 184	1.00
1. 00 ADMI 2. 00 OPER 3. 00 HOUS 4. 00 DI ET 5. 00 NURS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 OPER 12. 00 RADI 13. 00 LABC 14. 00 RESE	COACH RECLASS		14, 533	3, 184	
2. 00 OPER 3. 00 HOUS 4. 00 DI ET 5. 00 NURS 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 OPER 12. 00 RABU 13. 00 RESE					
3. 00 HOUS 4. 00 DI ET 5. 00 NURS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 11. 00 OPER 12. 00 RADI 13. 00 LABO 14. 00 RESE	MINISTRATIVE & GENERAL	5. 00	110, 395	0	1.00
4. 00 DI ET 5. 00 NURS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 11. 00 OPER 12. 00 RADI 13. 00 LABO 14. 00 RESF	RATION OF PLANT	7. 00	483	0	2.00
5. 00 NURS 6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 12. 00 RADI 13. 00 LABO 14. 00 RESF	JSEKEEPI NG	9. 00	3, 396	0	3.00
6. 00 CENT 7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 PREDI 12. 00 RADI 13. 00 LABO 14. 00 RESP	TARY	10.00	2, 197	0	4.00
7. 00 PHAR 8. 00 MEDI 9. 00 ADUL 10. 00 INTE 11. 00 OPER 12. 00 RADI 13. 00 LABC 14. 00 RESF	RSING ADMINISTRATION	13. 00	8, 796	0	5.00
8. 00 MEDI 9. 00 ADUL 10. 00 I NTE 11. 00 OPER 12. 00 RADI 13. 00 LABO 14. 00 RESE	ITRAL SERVICES & SUPPLY	14. 00	395	0	6.00
9. 00 ADUL 10. 00 INTE 11. 00 OPER 12. 00 RADI 13. 00 LABO 14. 00 RESP	ARMACY	15. 00	4, 338	0	7.00
10. 00 INTE 11. 00 OPER 12. 00 RADI 13. 00 LABO 14. 00 RESP	DICAL RECORDS & LIBRARY	16. 00	38, 222	0	8.00
11. 00 OPER 12. 00 RADI 13. 00 LABO 14. 00 RESP	JLTS & PEDIATRICS	30.00	26, 545	0	9, 00
12. 00 RADI 13. 00 LABO 14. 00 RESP	ENSIVE CARE UNIT	31.00	12, 250	0	10.00
13. 00 LABO 14. 00 RESP	ERATING ROOM	50.00	6, 716	0	11.00
14.00 RESP	OLOGY-DI AGNOSTI C	54.00	4, 786	0	12.00
	BORATORY	60.00	2,606	0	13.00
	SPI RATORY THERAPY	65. 00	5, 005	0	14.00
15.00 PHYS	SI CAL THERAPY	66. 00	4, 438	0	15. 00
	RDI AC REHAB	69. 01	2, 428	Ö	16.00
	ERGENCY	91.00	18, 772	Ö	17. 00
18.00 CLIN		93. 00	55, 868	0	18.00
	I DIAGNOSTIC CENTER	191. 01	2, 222	0	19.00
	LNESS	191. 02	1, 080	0	20.00
	SICIANS' PRIVATE OFFICES	192.00	1, 232	0	21.00
	RKETING	192. 02	902	0	22.00
23.00 WVCF		192. 07	27, 079	0	23. 00
TOTA			340, 151	0	-51.55
F -	HOSPITAL UTILITIES		2.0,.0.1	-1	
	ERATION OF PLANT	7. 01	0	615, 484	1.00
TOTA				615, 484	
	· IMPLANTABLE DEVICES		<u> </u>	210/101	
	PL. DEV. CHARGED TO	72.00	O	231, 111	1.00
		1 .2.00	٩	20.,	00
TOTA	TENTS	l l			
500.00 Gran	<u> </u>	<del>                                     </del>		231, 111	

Peri od: Worksheet A-6 From 10/01/2018 To 07/15/2019 Date/Time Prepared:

					1	o 07/15/2019	Date/lime Prepared: 12/18/2019 2:44 pm
		Decreases					127 107 20 17 2. 44 pin
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	A - CAFETERIA		<u> </u>				
1.00	DI ETARY	10.00	184, 509	143, 197	0		1.00
	TOTALS		184, 509	143, 197			
	B - NURSERY						
1.00	ADULTS & PEDIATRICS	30.00	14, 533	3, 184	. 0		1.00
	TOTALS		14, 533	3, 184			
	C - COACH RECLASS	•			,		
1.00	ADMINISTRATIVE & GENERAL	5. 00	340, 151	C	0		1.00
2.00		0.00	O	O	o		2.00
3.00		0.00	o	O	o		3.00
4.00		0.00	o	0	o		4.00
5.00		0.00	o	0	o		5. 00
6.00		0.00	0	0	0		6. 00
7. 00		0.00	o	0	o		7. 00
8. 00		0.00	o	0	o		8.00
9. 00		0.00	o	0	o		9.00
10.00		0. 00	o o	0	- 1		10.00
11. 00		0. 00	0	0	- 1		11.00
12. 00		0. 00	o o	0	0		12.00
13. 00		0. 00	o o	0			13.00
14. 00		0.00	0	0	- 1		14.00
15. 00		0.00	o	0			15. 00
16. 00		0.00		0			16.00
17. 00		0.00	0	0	- 1		17. 00
18. 00		0.00		0			18.00
19. 00		0.00	0	0			19.00
20. 00		0.00	0	0			20.00
21. 00		0.00		0			21. 00
22. 00		0.00		0	- 1		22.00
23. 00		0.00		0	1 4		23.00
23.00	TOTALS — — — —		340, 151	0			23.00
	E - HOSPITAL UTILITIES		340, 131				
1. 00	OPERATION OF PLANT	7. 00	0	615, 484	. 0		1.00
1.00	TOTALS	7.00		<u>615, 4</u> 64 615, 484			1.00
	F - IMPLANTABLE DEVICES		U	010, 484	1		
1. 00	CENTRAL SERVICES & SUPPLY	14. 00		231, 111			1.00
1.00	TOTALS		_ — — ∯	23 <u>1, 1</u> 11 231, 111			1.00
500 00	Grand Total: Decreases		539, 193	992, 976			500.00
300.00	oranu rotar. Decreases	l l	337, 173	992, 970	1		500.00

| Period: | Worksheet A-7 | From 10/01/2018 | Part | To 07/15/2019 | Date/Time Prepared: Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0064

				To	07/15/2019	Date/Time Pre 12/18/2019 2:	pared:
				Acqui si ti ons		12/10/2019 2.	44 piii
		Beginning	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	1, 003, 725	0	0	0	0	1.00
2.00	Land Improvements	492, 075	0	0	0	0	2.00
3.00	Buildings and Fixtures	53, 295, 798	0	0	0	11, 660, 880	3.00
4.00	Building Improvements	0	0	0	0	0	4. 00
5.00	Fixed Equipment	18, 492, 028	0	0	0	0	5.00
6.00	Movable Equipment	7, 602, 966	11, 734, 559	0	11, 734, 559	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	80, 886, 592	11, 734, 559	0	11, 734, 559	11, 660, 880	
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	80, 886, 592	11, 734, 559	0	11, 734, 559	11, 660, 880	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
	DART I ANALYGIC OF GUANGES IN GARLEAU ACCE	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						4 00
1.00	Land	1, 003, 725	0			ļ	1.00
2.00	Land Improvements	492, 075	0			l	2.00
3.00	Buildings and Fixtures	41, 634, 918	0			ļ	3.00
4. 00	Building Improvements	10 402 020	U			l	4.00
5.00	Fi xed Equi pment	18, 492, 028	U			l	5.00
6. 00 7. 00	Movable Equipment	19, 337, 525	0			ļ	6. 00 7. 00
7. 00 8. 00	HIT designated Assets Subtotal (sum of lines 1-7)	80, 960, 271	0			ļ	8.00
9. 00	Reconciling Items	00, 900, 271	0			ļ	9.00
10.00	Total (line 8 minus line 9)	80, 960, 271	0			ļ	10.00
10.00	Total (Tine o minus Tine 7)	00, 700, 271	υĮ			ļ	10.00

Heal th	Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019		pared:
			Sl	JMMARY OF CAP	PI TAL		
	Cost Center Description	Depreci ati on	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WO	DRKSHEET A, COLU	MN 2, LINES 1	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	1, 204, 215	0		0	0	1.00
3.00	Total (sum of lines 1-2)	1, 204, 215	0		0 0	0	3.00
		SUMMARY C	OF CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 204, 215		·		1.00
3. 00	Total (sum of lines 1-2)	0	1, 204, 215				3.00

Health Financial Systems	AYETTE REGIONAL	HEALTH SYSTEM	1	In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
				From 10/01/2018 Fo 07/15/2019		narod:
				10 07/13/2019	12/18/2019 2:	
	COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
			col . 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS		1				
1.00 CAP REL COSTS-BLDG & FIXT	80, 960, 271	l .				1.00
3.00 Total (sum of lines 1-2)	80, 960, 271		00/.00/			3. 00
	ALLUCA	TION OF OTHER	JAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
cost center bescription	Taxes	Capi tal -Rel at		Depi eci ati on	Lease	
		ed Costs	through 7)			
	6, 00	7.00	8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS				1.22	10.00	
1. 00 CAP REL COSTS-BLDG & FLXT	0	0		1, 196, 361	0	1.00
3.00 Total (sum of lines 1-2)	0	0	)	1, 196, 361	0	3.00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at		
		instructions)		ed Costs (see	9 through 14)	
	11.00	10.00	10.00	instructions)	45.00	
DADT III DECONCLITATION OF CARLTAL COCTO	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS  1.00 CAP REL COSTS-BLDG & FLXT	<u> </u>		ı ,		1 100 221	1 00
1.00 CAP REL COSTS-BLDG & FLXT 3.00 Total (sum of lines 1-2)	-7, 040		1	0 0		1. 00 3. 00
3.00   Total (Suill Of TitleS 1-2)	-7, 040	ıl O	'II	ار ار	1, 189, 321	3.00

ADJUST	MENTS TO EXPENSES				Peri od: From 10/01/2018	Worksheet A-8	
					To 07/15/2019	Date/Time Pre 12/18/2019 2:	pared: 44 pm
			_	Expense Classification of			
				o/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - CAP REL			AP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0 *	** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)		0			0	
4. 00	Trade, quantity, and time discounts (chapter 8)				0. 00	Ü	
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		О		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay		o		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		O		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		О		0.00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-5, 222, 888			0	10.00
11. 00	Sale of scrap, waste, etc.		О		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	О			0	12.00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14.00	Cafeteria-employees and guests		o		0. 00	0	14.00
15. 00	Rental of quarters to employee and others		O		0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than	А	-4, 761 M	EDICAL RECORDS & LIBRARY	16. 00	0	16. 00
47.00	pati ents				0.00		47.00
17. 00	Sale of drugs to other than patients		0		0.00	0	
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health		O		0. 00	0	19. 00
	education (tuition, fees, books, etc.)						
	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
200	interest, finance or penalty				3. 55	J	200
22. 00	charges (chapter 21) Interest expense on Medicare		O		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	OR	ESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0 P	HYSI CAL THERAPY	66. 00		24. 00
05.00	limitation (chapter 14)			** 0 0 8.1 8.1	444.00		05.00
25. 00	Utilization review - physicians' compensation		0 ^	** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		olc	AP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
	COSTS-BLDG & FLXT						
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP			** Cost Center Deleted ***		0	27.00
	Non-physician Anesthetist Physicians' assistant		0 *	** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
	Adjustment for occupational	A-8-3	0 *	** Cost Center Deleted ***		U	30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		O A	DULTS & PEDIATRICS	30. 00		30. 99
	instructions)	I	ı I				ı

				To	07/15/2019	Date/Time Pre 12/18/2019 2:	
				Expense Classification on	Worksheet A	12/10/2017 2.	тт рііі
				To/From Which the Amount is			
					•		
		5 , ,,		0 1 0 1	"		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)	2.00	2.00	4.00	Ref.	
31. 00	Adjustment for speech	1. 00 A-8-3	2. 00	3.00 *** Cost Center Deleted ***	4. 00 68. 00	5. 00	31.00
31.00	pathology costs in excess of	A-0-3	U	Cost Center Dereted	00.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32.00
02.00	Depreciation and Interest		ŭ		0.00	ŭ	02.00
33.00	MI SC REVENUE	В	-157, 025	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33. 01	RENTAL INCOME	В		OPERATION OF PLANT	7. 00	0	33. 01
33. 02	MISC REVENUE	В		PHARMACY	15. 00	0	33. 02
33. 03	MI SC REVENUE	В	-6, 068	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 03
33.04	MI SC REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 04
33.05	MI SC REVENUE	В		LABORATORY	60.00	0	33. 05
33.06	MI SC REVENUE	В	3, 000	PHYSI CAL THERAPY	66. 00	0	33.06
33.07	MI SC REVENUE	В		EMERGENCY	91. 00	0	33. 07
33. 08	INTEREST OFFSET	A	-7, 040	CAP REL COSTS-BLDG & FIXT	1. 00	11	33. 08
33. 09	CAFETERIA SALES-OTHER REV	В	-146, 293	CAFETERI A	11. 00	0	33. 09
33. 10	I HA DUES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 11	TELEVI SI ON	A	-312	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	24TH ST DEPRECIATION	A	·	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 12
33. 13	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 14	340B REVENUE	A		PHARMACY	15. 00	0	33. 14
33. 15	HAF OFFSET	A	-1, 185, 245	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 16
00 47	(3)						00 47
33. 17	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 17
22 10	(3)		0		0.00	0	22 10
33. 18	OTHER ADJUSTMENTS (SPECIFY) (3)		U		0. 00	U	33. 18
33. 19	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 19
33. 17	(3)		U		0.00	0	33. 17
33. 20	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 20
00. 20	(3)		Ö		0.00	· ·	00.20
33. 21	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 21
	(3)						
33. 22	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 22
	(3)						
33. 23	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 23
	(3)						
33. 24	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 24
	(3)						
33. 25	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 25
	(3)		7 (07 :				
50.00	TOTAL (sum of lines 1 thru 49)		-7, 607, 650				50.00
	(Transfer to Worksheet A,						
(1) 5	column 6, line 200.)						L

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0064

						-	To 07/15/2019	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi or	nal Pr	ovi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Componen	t Co	mponent		ider Component	
								Hours	
	1.00	2. 00	3. 00	4. 00		5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	931, 629			0	1		
2.00		OPERATING ROOM	355, 124		124	0	0	0	2. 00
3.00		RADI OLOGY-DI AGNOSTI C	361, 692		692	0	0	0	3. 00
4.00		LABORATORY	48, 750		750	0	0	0	4. 00
5. 00		EMERGENCY	1, 039, 284			0	0	0	5. 00
6.00		CLINIC	2, 491, 917	2, 480,	984	10, 933	179, 000	1	6. 00
7. 00	0.00		0		0	0	0	0	7. 00
8. 00	0.00		0		0	0	0	0	8. 00
9. 00	0.00		0		O	0	0	0	9. 00
10.00	0. 00		0		0	0	0	0	10.00
200.00			5, 228, 396			10, 933			200.00
	Wkst. A Line #	l 3	Unadjusted RCE			ost of	Provi der	Physician Cost	
		Identifier	Limit	Unadj usted			Component	of Malpractice	
				Limit		nti nui ng	Share of col.	Insurance	
	1.00	2.00	0.00	0.00		ucation	12	14.00	
1 00	1.00	2.00	8. 00	9. 00		12.00	13. 00	14.00	1.00
1.00		ADULTS & PEDIATRICS	0		0	0	_	-	
2.00		OPERATING ROOM	0		0	· ·		-	2.00
3.00		RADI OLOGY-DI AGNOSTI C	0		0	0	_	_	3.00
4. 00 5. 00		LABORATORY EMERGENCY	0		0	0	0	1	4.00
			5 500		۰	0	0	0	5.00
6. 00		CLINIC	5, 508		275	0	0	0	6.00
7. 00	0.00		0		0	0	0	0	7.00
8. 00	0.00		0		0	0	0	0	8. 00
9. 00	0.00		0		0	0	0	0	9.00
10.00	0.00		U		275	0	0	· ·	10.00
200.00	Wkst. A Line #	Cook Cook or (Dhore) of or	5, 508 Provi der		275	RCE	0	0	200.00
	wkst. A line #	Cost Center/Physician Identifier		Adjusted F		allowance	Adjustment		
		rdentrirei	Component Share of col.	LIIIII	טו אמ	ai i owance			
			14						
	1. 00	2.00	15. 00	16. 00		17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	13.00		0	17.00			1. 00
2. 00		OPERATING ROOM			0	0	355, 124		2.00
3. 00		RADI OLOGY-DI AGNOSTI C			0	0	361, 692		3. 00
4. 00		LABORATORY			0	0	48, 750		4.00
5. 00		EMERGENCY			0	0	1, 039, 284		5.00
6. 00		CLI NI C		5	508	5, 425			6. 00
7. 00	0.00			٥,	0	3, 423	2, 400, 407	1	7. 00
8. 00	0.00				0	0	0		8. 00
9. 00	0.00				0	0			9.00
10.00	0.00	1			0	0			10.00
200.00	0.00			5	508	5, 425	5, 222, 888		200.00
200.00	I	I	, 0	١,	200	5, 725	1 5, 222, 000	1	

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 10/01/2018 Part I
To 0/15/2019 Patt View Propagate Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0064

				T	07/15/2019	Date/Time Pre	pared:
			CAPI TAL			12/18/2019 2:	44 pm
			RELATED COSTS				
	Cost Center Description	Net Expenses	BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI V	
		for Cost		BENEFITS		E & GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A col. 7)					
		0	1.00	4. 00	4A	5. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT	1, 189, 321	1, 189, 321				1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 686, 844			, 057 ,07	,	4.00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	6, 608, 770 623, 088			6, 857, 427 1, 244, 973		5. 00 7. 00
	00700 OPERATION OF PLANT	615, 484			615, 484		1
	00800 LAUNDRY & LINEN SERVICE	92, 379		_	93, 805		1
9. 00	00900 HOUSEKEEPI NG	427, 337	5, 869		474, 859		1
	01000 DI ETARY	353, 407	8, 198		385, 567		1
	01100 CAFETERI A	181, 413	· ·		215, 424		1
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	527, 523 157, 582	0 7, 803	,	586, 539 172, 131		
	01500 PHARMACY	1, 193, 063			1, 229, 589		15.00
	01600 MEDICAL RECORDS & LIBRARY	697, 294			783, 428		1
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	1, 859, 834	35, 849		2, 070, 571	711, 136	1
	03100 I NTENSI VE CARE UNI T	774, 214	25, 562		881, 643		1
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	0	0	0	0 0	40. 00 41. 00
	04200 SUBPROVI DER	0		0	0	0	42.00
	04300 NURSERY	17, 717	13, 539	1, 742	32, 998	_	1
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	403, 806			512, 794		1
	05400 RADI OLOGY-DI AGNOSTI C	1, 528, 928			1, 646, 303		54.00
	06000 LABORATORY 06500 RESPI RATORY THERAPY	1, 060, 738 319, 330			1, 136, 432 363, 350		1
	06600 PHYSI CAL THERAPY	279, 836			328, 757		66.00
	06900 ELECTROCARDI OLOGY	0	0	0	0		69.00
	06901 CARDI AC REHAB	159, 115	8, 660	16, 438	184, 213		1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	231, 111	0	_	231, 111 0	79, 375 0	1
	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	73.00
91.00	09100 EMERGENCY	1, 092, 212	24, 714	117, 442	1, 234, 368	423, 942	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	04050 CLI NI C	1, 280, 059	· ·		1, 726, 623		
	04950  BI C 04954  PODI ATRY	0	0		0		
	OTHER REIMBURSABLE COST CENTERS	0		0	0		93.03
	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
	10100 HOME HEALTH AGENCY	0	0		0	0	101. 00
-	SPECIAL PURPOSE COST CENTERS						
	11600 HOSPI CE	0	0				116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	23, 360, 405	1, 059, 127	1, 469, 643	23, 008, 389	5, 547, 031	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0			0		191.00
	19101 FMH DIAGNOSTIC CENTER	136, 928	0	13, 615	150, 543	51, 704	191. 01
	19102 WELLNESS	143, 306			176, 789		191. 02
	19200 PHYSICIANS' PRIVATE OFFICES 19201 RFE	5, 785			9, 528		192.00
	19201 MARKETI NG	167 70, 904	0 3, 790	_	167 80, 642		192. 01 192. 02
	19203 FOUNDATION	0	4, 095		4, 095		192.03
	19206 HEART CENTER	0	2, 739		2, 739		192.06
	19207 WVCP	2, 552, 307			2, 797, 513		1
	19208 OCCUPATI ONAL MED	1, 126			1, 126		192.08
	19210 HOSPITALIST 07950 OTHER NONREIMBURSABLE COST CENTERS	453, 573	28, 336	0	453, 573 28, 336		192. 10 194. 00
	07950 OTHER NONREIMBURSABLE COST CENTERS	99, 268		11, 061	28, 336 110, 329		194.00
200.00	Cross Foot Adjustments	,,,200		1., 301	0		200.00
201.00	Negative Cost Centers		0	0	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	26, 823, 769	1, 189, 321	1, 691, 465	26, 823, 769	6, 857, 427	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0064

Peri od: Worksheet B From 10/01/2018 Part I To 07/15/2019 Date/Ti me Prepared:

				'	0 07/13/2019	12/18/2019 2:	
	Cost Center Description	OPERATION OF PLANT	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	<b></b>
		7. 00	7. 01	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	4 (70 550					5.00
7.00	00700 OPERATION OF PLANT	1, 672, 558	004 071				7. 00 7. 01
7. 01 8. 00	00701 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	4, 583	826, 871 3, 336	1			8.00
9. 00	00900 HOUSEKEEPI NG	18, 865	13, 730	1	670, 544		9.00
10.00	01000 DI ETARY	26, 351	19, 178	1		588, 939	10.00
11. 00	01100 CAFETERI A	38, 244	27, 833	1	15, 941	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	25, 082	18, 254	1	10, 455	0	14.00
15.00	01500 PHARMACY	24, 270	17, 663	1		0	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	36, 377	26, 474	0	15, 162	0	16. 00
30. 00	O3000 ADULTS & PEDIATRICS	115, 226	83, 858	33, 981	48, 028	308, 106	30.00
31. 00	03100 INTENSIVE CARE UNIT	82, 163	59, 796	1	34, 247	30, 366	31.00
40. 00	04000 SUBPROVI DER – I PF	02,100	0,,,,0	0	0 1, 2 1,	0	40.00
41.00	04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43.00	04300 NURSERY	43, 518	31, 671	0	18, 139	0	43.00
<b>50.00</b>	ANCILLARY SERVICE COST CENTERS	101 701		10.44	04.400		
50.00	05000 OPERATING ROOM	194, 794	141, 766		81, 193	0	50.00
54. 00 60. 00	05400   RADI OLOGY-DI AGNOSTI C   06000   LABORATORY	139, 916 66, 649	101, 827 48, 505		58, 319 27, 780	0	54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	33, 474	24, 361	1	13, 952	0	65.00
66. 00	06600 PHYSI CAL THERAPY	60, 189	43, 804			0	66.00
69. 00	06900 ELECTROCARDI OLOGY	00, 107	43, 004	13, 440	25, 000	0	69.00
69. 01	06901 CARDI AC REHAB	27, 836	20, 258	1, 133	11, 602	Ō	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS			1			
91.00	09100 EMERGENCY	79, 437	57, 812	23, 746	33, 111	0	91.00
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04050 CLINIC	237, 116	53, 485	85	98, 834	0	92. 00 93. 00
93. 00	04950 BI C	237, 110	55, 465 0	0	70, 034	0	93.00
93. 05	04954 PODI ATRY	o	0	ő	o	Ö	93.05
	OTHER REIMBURSABLE COST CENTERS				· ·		
	09500 AMBULANCE SERVICES	0	0	0			95.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
44/ 0/	SPECIAL PURPOSE COST CENTERS			1			144 00
116.00	)11600 HOSPICE 	0 1, 254, 090	793, 611	1		0 338, 472	116.00
110.00	NONREI MBURSABLE COST CENTERS	1, 234, 090	793,011	131, 349	312, 931	330, 472	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191.00	19100 RESEARCH	o	0	Ō	-		191.00
191. 01	19101 FMH DIAGNOSTIC CENTER	0	0	0	0	0	191. 01
	2 19102 WELLNESS	84, 879	0	0	35, 379		191. 02
	19200 PHYSICIANS' PRIVATE OFFICES	11, 556	8, 410	2, 158	4, 817		192.00
	19201 RFE	0	0	0	0		192. 01
	19202 MARKETI NG	12, 182	8, 865		5, 077		192. 02
	3 19203 FOUNDATION	13, 162	9, 579	1	5, 486	0	192. 03 192. 06
	5 19206 HEART CENTER 7 19207 WVCP	8, 802 196, 810	6, 406	434	-,	250, 467	
	19208 OCCUPATI ONAL MED	170, 010	0	1 434	00, 713		192.08
	19210 HOSPI TALI ST	0	0	Ö	o		192. 10
	07950 OTHER NONREIMBURSABLE COST CENTERS	91, 077	0	Ö	22, 450		194.00
	07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	O		194. 01
200.00							200. 00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	1, 672, 558	826, 871	133, 941	670, 544	588, 939	202. 00

Provider CCN: 15-0064

Peri od: Worksheet B From 10/01/2018 Part I To 07/15/2019 Date/Time Prepared:

			То	07/15/2019	Date/Time Pre 12/18/2019 2:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
·		ADMI NI STRATI O	SERVICES &		RECORDS &	
	44.00	N	SUPPLY	45.00	LI BRARY	
GENERAL SERVICE COST CENTERS	11. 00	13. 00	14. 00	15. 00	16. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
7.01   OO701 OPERATION OF PLANT						7. 01
8.00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A	371, 429	1				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	10, 449		207 472			13. 00 14. 00
14.00   01400   CENTRAL SERVI CES & SUPPLY 15.00   01500   PHARMACY	2, 433 7, 207		287, 473	1 711 1/6		15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	23, 511		0	1, 711, 146	1, 154, 020	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	23, 311	<u> </u>	0	<u> </u>	1, 134, 020	10.00
30. 00 03000 ADULTS & PEDIATRICS	44, 071	142, 951	0	0	136, 903	30.00
31. 00 03100 I NTENSI VE CARE UNI T	20, 751	67, 305	0	o	29, 990	31.00
40. 00   04000   SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00   04100   SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NURSERY	613	1, 986	0	0	538	43.00
ANCILLARY SERVICE COST CENTERS	10.070	40.075		اه	50.077	
50. 00   05000   OPERATING ROOM	13, 279		0	0	50, 377	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY	19, 622 19, 355		0	0	238, 271	54. 00 60. 00
65. 00   06500   RESPI RATORY THERAPY	9, 892		0	0	184, 618 44, 902	65.00
66. 00   06600 PHYSI CAL THERAPY	8, 285		0	0	15, 873	66.00
69. 00 06900 ELECTROCARDI OLOGY	0, 200	20,070	0	Ö	0	69.00
69. 01   06901 CARDI AC REHAB	4, 816	15, 624	0	o	6, 465	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	287, 473	О	12, 037	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9, 841	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	1, 711, 146	92, 429	73.00
OUTPATIENT SERVICE COST CENTERS			-1	.1		
91. 00 09100 EMERGENCY	30, 780	99, 832	0	0	196, 559	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	74 400	242 252	0	0	105 017	92.00
93. 00   04050  CLI NI C 93. 01   04950  BI C	74, 689	242, 252	0	0	135, 217 0	93. 00 93. 01
93. 05   04954   PODI ATRY	0		0	0	0	93.05
OTHER REIMBURSABLE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		75.05
95. 00 09500 AMBULANCE SERVI CES	0	O	0	0	0	95. 00
101.00 10100 HOME HEALTH AGENCY	Ō		0	o		101.00
SPECIAL PURPOSE COST CENTERS						
116. 00 11600 HOSPI CE	0		0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	289, 753	798, 434	287, 473	1, 711, 146	1, 154, 020	118. 00
NONREI MBURSABLE COST CENTERS	_			ام		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190. 00 191. 00
191. 00 19100 RESEARCH 191. 01 19101 FMH DI AGNOSTI C CENTER	0	0	0	0		191.00
191. 02 19102 WELLNESS	4, 232		0	0		191.01
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 463		0	0		192.00
192. 01 19201 RFE	0, 100		Ö	ol		192. 01
192. 02 19202 MARKETI NG	0	0	0	0		192. 02
192. 03 19203 FOUNDATI ON	0	0	0	o	0	192. 03
192.06 19206 HEART CENTER	0	0	0	o		192. 06
192. 07 19207 WVCP	73, 981	0	0	0		192. 07
192. 08 19208 OCCUPATI ONAL MED	0	0	0	0		192. 08
192. 10 19210 HOSPI TALI ST	0	0	0	0		192. 10
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194.00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 200. 00 Cross Foot Adjustments		۱	O	이	0	194. 01 200. 00
201.00 Negative Cost Centers	_		n	n	Λ	200.00
202.00 TOTAL (sum lines 118 through 201)	371, 429	798, 434	287, 473	1, 711, 146	1, 154, 020	
, , , , , , , , , , , , , , , , , , , ,						

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-2552-10 Peri od: Worksheet B
From 10/01/2018 Part I
To 07/15/2019 Date/Ti me Prepared: 12/18/2019 2: 44 pm Provider CCN: 15-0064 Cost Center Description Total Subtotal Intern & Resi dents Cost & Post

			Stepdown		
			Adjustments		
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT				1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL				5.00
7. 00	00700 OPERATION OF PLANT				7. 00
7. 01	00701 OPERATION OF PLANT				7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE				8.00
9. 00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON				13.00
	01400 CENTRAL SERVICES & SUPPLY				14. 00
	01500 PHARMACY				15. 00
	01600 MEDICAL RECORDS & LIBRARY				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	3, 694, 831	0	3, 694, 831	30.00
	03100 INTENSIVE CARE UNIT	1, 521, 451	o	1, 521, 451	31.00
	04000 SUBPROVI DER - I PF	0	o	0	40.00
41.00	04100 SUBPROVI DER - I RF	o	o	0	41.00
42.00	04200 SUBPROVI DER	0	o	0	42.00
43.00	04300 NURSERY	140, 796	О	140, 796	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	1, 225, 538	0	1, 225, 538	50.00
54.00	05400   RADI OLOGY-DI AGNOSTI C	2, 851, 317	0	2, 851, 317	54.00
60.00	06000 LABORATORY	1, 936, 448	0	1, 936, 448	60.00
65.00	06500 RESPI RATORY THERAPY	646, 809	0	646, 809	65.00
66.00	06600 PHYSI CAL THERAPY	637, 225	0	637, 225	66. 00
	06900 ELECTROCARDI OLOGY	0	0	0	69. 00
	06901 CARDI AC REHAB	335, 215	0	335, 215	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	299, 510	0	299, 510	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	320, 327	0	320, 327	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 803, 575	0	1, 803, 575	73. 00
01 00	OUTPATIENT SERVICE COST CENTERS	2 170 507	ما	2 170 507	01 00
	09100 EMERGENCY	2, 179, 587	0	2, 179, 587	91.00 92.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 04050 CLINIC	3, 161, 308	0	3, 161, 308	93.00
93. 00	04950 BI C	3, 101, 300	0	3, 101, 306	93.00
	04954 PODI ATRY	0	o	0	93. 05
73.03	OTHER REIMBURSABLE COST CENTERS	<u> </u>	<u> </u>	O <sub>I</sub>	75.05
95.00	09500 AMBULANCE SERVICES	0	0	0	95. 00
	10100 HOME HEALTH AGENCY	0	o	0	101.00
	SPECIAL PURPOSE COST CENTERS	- 1		-	
116.00	11600 HOSPI CE	0	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	20, 753, 937	0	20, 753, 937	118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	190. 00
	19100 RESEARCH	0	0	0	191. 00
	19101 FMH DIAGNOSTIC CENTER	202, 247	0	202, 247	191. 01
	19102 WELLNESS	361, 997	0	361, 997	191. 02
	19200 PHYSICIANS' PRIVATE OFFICES	43, 204	0	43, 204	192. 00
	19201 RFE	224	0	224	192. 01
	19202 MARKETI NG	134, 462	0	134, 462	192. 02
	19203 FOUNDATION	33, 728	0	33, 728	192. 03
	19206 HEART CENTER	22, 557	0	22, 557	192.06
	19207 WVCP	4, 360, 732	0	4, 360, 732	192.07
	19208 OCCUPATI ONAL MED	1, 513	0	1, 513	192. 08
	19210 HOSPI TALI ST	609, 352	0	609, 352	192. 10
	07950 OTHER NONRELMBURSABLE COST CENTERS	151, 595	0	151, 595	194. 00 194. 01
200.00	07951 OTHER NONREI MBURSABLE COST CENTERS	148, 221 0	0	148, 221 0	200.00
200.00	3	0	0	0	200.00
201.00		26, 823, 769	0	26, 823, 769	201.00
202.00	TOTAL (Sum TINGS TTO LINGUIGHT 201)	20,023,707	۰Į	20,023,107	1202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 10/01/2018 | Part II | To 07/15/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0064

Cust Centur Description						o 07/15/2019		
COST CENTER DESCRIPTION				CAPI TAL			12/18/2019 2:	44 piii
Assignment flows   Selection				RELATED COSTS				
ENTROL STRUCT COST CINITIES		Cost Center Description		BLDG & FIXT	Subtotal			
Billetal SERVICE COST CENTERS							E & GENERAL	
CENTRAL SERVICE COST CENTERS   1.00			•			DEPARIMENT		
ERERAL SERVICE COST CENTERS 1.00 001000 JURI-DUYCE BUREFITS CHARATERITY 1.00 001000 JURI-DUYCE BUREFITS 1.00 001000 JURI-D				1.00	2A	4. 00	5. 00	
4.00   0.0400   DMPLOVER BENEFITS DEPARTIENT   0   4.021   4.021   4.021   4.021   7.0   7.0   7.0   0.0070   DMPLOVER SERVICE   0.00700   DEPARTION OF PLANT   0   5.0   5.0   0.00500   DEPARTION OF PLANT   0   0.00700   0.00700   DEPARTION OF PLANT   0   0   1.00700   0.00		GENERAL SERVICE COST CENTERS		11.00		11.00	0.00	
0.0000   AMIN INSTRATIVE & GENERAL   0   74, 562   74, 562   475   75, 567   5.00	1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
0,000   0,00			-					•
7.01 0.701   OPERATION OF PLANT   0			-					ł
9.00   00900   LANDRY & LINEN SERVICE   0   1.426   1.426   0   333   0.00     9.00   00900   DUSEXEEPIN   0   8.198   8.198   65   1.447   10.00     10.00   10000   DETARY   0   8.198   8.198   65   1.447   10.00     13.00   01000   DETARY   0   7.800   7.800   7.800   11.40     13.00   01300   MIRSINK DAMI ISTRATION   0   7.800   7.800   7.800   11.300     15.00   01300   MIRSINK DAMI ISTRATION   0   7.800   7.800   7.800   11.300     15.00   01300   MIRSINK DAMI ISTRATION   0   7.800   7.800   7.800   7.800     15.00   01300   MIRSINK DAMI ISTRATION   0   7.800   7.800   7.800   7.800     16.00   01600   MEDICAL RECORDS & LIBRARY   0   11.318   11.318   204   2.945     16.00   1600   MEDICAL RECORDS & LIBRARY   0   11.318   11.318   204   2.945     16.00   1600   MEDICAL RECORDS & LIBRARY   0   13.5849   35.849   37.77   7.733   30.00     10.00   01600   MIRSINK DAMI ISTRATION   0   25.562   25.562   22.3   3.14   31.00     10.00   01600   MIRSINK DAMI ISTRATION   0   25.562   25.562   22.3   3.14   31.00     10.00   01600   MIRSINK DAMI ISTRATION   0   20.00   0   0   0   0     10.00   01600   MIRSINK DAMI ISTRATION   0   25.562   25.562   22.3   3.14   31.00     10.00   01600   MIRSINK DAMI ISTRATION   0   20.00   0   0   0   0   0     10.00   01600   MIRSINK DAMI ISTRATION   0   20.00   0   0   0   0   0     10.00   01600   MIRSINK DAMI ISTRATION   0   20.00   0   0   0   0   0     10.00   01600   MIRSINK DAMI ISTRATION   0   20.00   0   0   0   0   0     10.00   01600   MIRSINK DAMI ISTRATION   0   0   0   0   0   0   0     10.00   01600   MIRSINK DAMI ISTRATION   0   0   0   0   0   0   0   0     10.00   01600   MIRSINK DAMI ISTRATION   0   0   0   0   0   0   0   0     10.00   01600   MIRSINK DAMI ISTRATION   0   0   0   0   0   0   0   0     10.00   01600   MIRSINK DAMI ISTRATION   0   0   0   0   0   0   0   0   0     10.00   01600   MIRSINK DAMI ISTRATION   0   0   0   0   0   0   0   0   0			C	1				•
9.00   09900   HOUSEKEEN NS		I I	C	1				•
10.00   01000   01000   01   ETARY   0								
11.00   01100   CAFETERIA   0   11.898   60   810   11.00		I I						•
13.00   01300   MURSI IN A SAMINI STRATION   0   0   0   161   2.05   13.00		I I						•
15.00   01500   PHARMACY   0   7,551   7,551   79   4,622   15.00   10.00   10.00   MEDICAL RECORDS & LIBRARY   0   11,318   12,318   204   2,945   16.00   10.00   000   000   001   17.551   17.578   10.00   10.00   000   001   17.551   17.578   10.00   10.00   000   001   17.551   17.578   10.00   10.00   000   001   00	13.00	01300 NURSING ADMINISTRATION	C	0	C	161	2, 205	13.00
16.00			1					•
INPATI ENT ROUTINE SERVICE COST CENTERS   0   35,849   35,849   477   7,783   30.00   31.00   30.100   31.00		· · · · · · · · · · · · · · · · · · ·	-					1
30.00	16.00			)  11, 318	11, 318	204	2, 945	16.00
31.00   03100   INTENSIVE CARE UNIT   0   25,562   25,562   223   3,31   31.00   0.0	30 00			35 849	35 840	477	7 783	30 00
40. 00   04000   SUBPROVI DER - I PF			1	1				1
A2. 00   04200   SUBPROVI DER   0			-		20,002			1
ABOOD   OBJOOD   OB	41.00	04100 SUBPROVI DER - I RF	C	0	C	0	0	41.00
ANCILLARY SERVICE COST CENTERS   So. 00   So. 00   OSCOO   OPERATIN ROM   O   O   60, 604   132   1,928   50. 00   54. 00   05400   RADIO LOCY-DI ACNOSTIC   O   43,530   43,530   201   6,188   54. 00   0.00   0	42.00				C	0	0	
SOLIC   05000   05000   05000   070000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   07000   070000   07000   07000   07000   07000   070000   070000   070000   070000   070000   0700000   0700000000	43.00		C	13, 539	13, 539	5	124	43.00
S4.0   0.5400   RADIO LOGY-DIAGNOSTIC   0   43, 530   43, 530   201   6, 188   54, 00   0.0	F0 00		1	10 (04	1 (0 (0)	1 400	4 000	
0.00   0.0000   LABORATORY   0   20,736   20,736   150   4,272   80,00   6.60,00   0.600   0.6500		I I						•
65. 00   06500   RESPI RATORY THERAPY   0   10,414   10,414   92   1,366   55. 00				10,000				•
66.00   06600   PHYSI CAL THERAPY   0   18,726   18,726   82   1,236   60,00   69.00   06900   ELECTROCARDIOLOCY   0   0   0   0   0   0   0   0   69.01   06901   CARDIAC REHAB   0   8,660   8,660   45   692   69,01   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   73.00   73.00   07300   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   73.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   73.00   07470   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   74.00   07900   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   75.00   07900   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   75.00   07900   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   75.00   07900   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0								•
69-01   06901   06901   06801   06801   06801   06801   06801   06801   06801   07100   0710		1 1						•
77. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0	69.00	06900 ELECTROCARDI OLOGY	C	0	C	0	0	69. 00
172.00   07200   IMPL DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0		1	C	8, 660	8, 660	45		•
73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73.00			1	1	C	0		•
OUTPATE ENT SERVICE COST CENTERS   O   O7100   EMERGENCY   O   O7200			-		1	0		•
91.00   09100   BMERGENCY   0   24,714   24,714   320   4,640   91.00   92.00   09200   09200   093.01   04950   BLC   0   0   0   0   0   0   0   0   0	73.00			)		0	0	73.00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   73,772   73,772   1,026   6,490   93. 00   93. 00   04950   BIC   0   0   0   0   0   0   0   0   93. 01   04950   BIC   0   0   0   0   0   0   0   0   93. 05   04954   POI ATRY   0   0   0   0   0   0   0   0   95. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0   0   0   101. 00   10100   HOME   HEALTH AGENCY   0   0   0   0   0   0   0   0   118. 00   SPECI AL PURPOSE COST CENTERS   0   0   0   0   0   0   0   0   116.00   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   1,059,127   1,059,127   4,017   60,712   118. 00   191. 00   19100   RESEARCH   0   0   0   0   0   0   0   0   191. 00   191. 00   19100   RESEARCH   0   0   0   0   0   0   0   191. 00   191. 01   19101   FMH DI AGNOSTI C CENTERS   0   0   0   0   0   0   0   191. 00   192. 01   19200   HYDIS (IANS' PRI VATE OFFI CES   0   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   0   0   192. 00   192. 01   19201   REFEARCH   0   0   0   0   0   0   0   0   0	91. 00			24. 714	24. 714	320	4, 640	91.00
93. 01		1 1		,,	c	-	.,	•
93. 05	93.00	04050 CLI NI C	C	73, 772	73, 772	1, 026	6, 490	93.00
### OF THER REIMBURSABLE COST CENTERS    95. 00   OTHER REIMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O		I I			1	-		
95. 00   09500   AMBULANCE SERVICES   0   0   0   0   0   0   0   0   0	93. 05		C	) 0	C	0	0	93. 05
101. 00   10100   HOME   HEALTH   AGENCY   D   D   D   D   D   D   D   D   D	05 00			) O		0	0	05.00
116. 00   11600   HOSPI CE   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				l control of the cont	•			
116. 00   11600   HOSPI CE   SUBTOTALS (SUM OF LINES 1 through 117)   0   1,059,127   1,059,127   4,017   60,712   118. 00	101.0			,		0	0	1101.00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   1,059,127   1,059,127   4,017   60,712   118. 00	116. 0		C	0	С	0	0	116.00
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 1910 RESEARCH 0 0 0 0 0 0 0 191. 00 191. 00 1910 RESEARCH 0 0 0 0 0 0 0 0 191. 00 191. 00 1910 RESEARCH 0 0 0 0 0 37 566 191. 01 191. 01 19101 FMH DIAGNOSTIC CENTER 0 0 26, 408 26, 408 19 665 191. 02 192. 01 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 3, 595 3, 595 0 36 192. 00 192. 01 19201 RFE 0 0 0 0 0 0 1 192. 01 192. 01 192. 01 192. 02 19202 MARKETI NG 0 3, 790 3, 790 16 303 192. 02 192. 03 19203 FOUNDATI ON 0 4, 095 4, 095 0 15 192. 03 192. 03 19203 FOUNDATI ON 0 4, 095 4, 095 0 10 192. 03 192. 04 HEART CENTER 0 0 2, 739 2, 739 0 10 192. 07 192. 08 19208 OCCUPATI ONAL MED 0 0 0 0 0 0 1, 705 192. 10 192. 10 19210 HOSPI TALI ST 0 0 0 0 0 0 1, 705 192. 10 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 28, 336 28, 336 0 107 194. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	C	1, 059, 127	1, 059, 127	4, 017		
191. 00   19100   RESEARCH						1		
191. 01   19101   FMH DI AGNOSTI C CENTER			•		C	0		
191. 02 19102 WELLNESS 0 26, 408 19 665 191. 02 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 3, 595 0 36 192. 00 192. 01 19201 RFE 0 0 0 0 0 0 1 192. 01 192. 01 192. 01 192. 01 192. 02 19202 MARKETI NG 0 3, 790 3, 790 16 303 192. 02 192. 03 192.03 FOUNDATI ON 0 4, 095 4, 095 0 15 192. 03 192. 06 192.06 192.06 192.06 HEART CENTER 0 2, 739 2, 739 0 10 192. 06 192. 07 192.07 WVCP 0 61, 231 61, 231 502 10, 518 192. 07 192. 08 192.08 192.09 OCCUPATI ONAL MED 0 0 0 0 0 4 192. 08 192. 10 19210 HOSPI TALI ST 0 0 0 0 0 1, 705 192. 10 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 28, 336 28, 336 0 107 194. 00 194. 01 07950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-	1	1	_		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 3, 595 0 36 192. 00 192. 01 19201 RFE 0 0 0 0 0 0 1 192. 01 192. 01 192. 01 192. 02 19202 MARKETI NG 0 3, 790 3, 790 16 303 192. 02 192. 03 19203 FOUNDATI ON 0 4, 095 4, 095 0 15 192. 03 192. 06 19206 HEART CENTER 0 2, 739 2, 739 0 10 192. 06 192. 07 19207 WVCP 0 61, 231 61, 231 502 10, 518 192. 07 192. 08 19208 OCCUPATI ONAL MED 0 0 0 0 0 4 192. 07 192. 10 19210 HOSPI TALI ST 0 0 0 0 0 1, 705 192. 10 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 28, 336 28, 336 0 107 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 28, 336 28, 336 0 107 194. 01 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I I	·		1			
192. 01   19201   RFE				,				
192. 02 19202 MARKETI NG 0 3, 790 16 303 192. 02 192. 03 19203 FOUNDATI ON 0 4, 095 4, 095 0 15 192. 03 192. 06 19206 HEART CENTER 0 2, 739 2, 739 0 10 192. 06 192. 07 19207 WVCP 0 61, 231 61, 231 502 10, 518 192. 07 192. 08 19208 OCCUPATI ONAL MED 0 0 0 0 4 192. 08 192. 10 19210 HOSPI TALI ST 0 0 0 0 1, 705 192. 10 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 28, 336 28, 336 0 107 194. 00 107951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0,070			
192. 06 19206 HEART CENTER 0 2, 739 2, 739 0 10 192. 06 192. 07 19207 WVCP 0 61, 231 61, 231 502 10, 518 192. 07 192. 08 19208 OCCUPATI ONAL MED 0 0 0 0 0 4 192. 08 192. 10 19210 HOSPI TALI ST 0 0 0 0 0 1, 705 192. 10 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 28, 336 28, 336 0 107 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 10 107 194. 01 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			C	3, 790	3, 790	16		
192. 07 19207 WVCP 0 61, 231 61, 231 502 10, 518 192. 07 192. 08 19208 0CCUPATI ONAL MED 0 0 0 0 0 4 192. 08 192. 10 19210 HOSPI TALI ST 0 0 0 0 0 1, 705 192. 10 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 28, 336 28, 336 0 107 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 30 415 194. 01 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I I	C	4, 095				
192. 08 19208 OCCUPATI ONAL MED  192. 10 19210 HOSPI TALI ST  194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS  194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS  195. 08 0 0 0 0 0 1, 705 192. 10  207. 00 0 0 0 0 0 194. 00  208. 336			C					
192. 10   19210   HOSPITALIST 0 0 0 0 0 1, 705   192. 10   194. 00   07950   OTHER NONREI MBURSABLE COST CENTERS 0 28, 336 0 107   194. 00   194. 01   07951   OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 30 415   194. 01   200. 00   Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	i e				
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 28, 336 0 107 194. 00 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 30 415 194. 01 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00		I I	-	1		-		
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 30 415 194. 01 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1	1	· ·		
200.00       Cross Foot Adjustments       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00				0	20, 330			
201.00   Negative Cost Centers   0   0   0   201.00								
202.00   TOTAL (sum lines 118 through 201)   0  1,189,321  1,189,321  4,621  75,057 202.00	201.00	Negative Cost Centers		0	C	0		
	202. 00	0   TOTAL (sum lines 118 through 201)	[ C	1, 189, 321	1, 189, 321	4, 621	75, 057	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0064

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 10/01/2018 Part II
To 07/15/2019 Date/Time Prepared: 12/18/2019 2:44 pm

				'	0 0771372017	12/18/2019 2:	
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT	PLANT	LINEN SERVICE			
		7. 00	7. 01	8. 00	9. 00	10. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	594, 523					7.00
7. 00	00700 OPERATION OF PLANT	374, 323	2, 314				7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 629	2, 311	3, 417			8.00
9. 00	00900 HOUSEKEEPI NG	6, 706	38	0, 117			9. 00
10.00	01000 DI ETARY	9, 367	54	368		19, 739	10.00
11. 00	01100 CAFETERI A	13, 594	78	0	345	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	0	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 916	51	0	226	0	14.00
15.00	01500 PHARMACY	8, 627	49	0	219	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	12, 930	74	0	328	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	40, 958	235	867		10, 326	30.00
31.00	03100 I NTENSI VE CARE UNI T	29, 205	167	316		1, 018	31.00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41.00
42.00	04200 SUBPROVI DER	15 4(0)	0	0	-	0	42.00
43. 00	04300 NURSERY	15, 469	89	0	393	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	69, 241	395	310	1 757	0	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	49, 734	285	459	·	0	54.00
60.00	06000 LABORATORY	23, 691	136	437		0	60.00
65. 00	06500 RESPI RATORY THERAPY	11, 898	68			0	65.00
66. 00	06600 PHYSI CAL THERAPY	21, 395	123	394	I	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	21, 373	0	0		0	69.00
69. 01	06901 CARDI AC REHAB	9, 894	57	29	-	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	O	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	28, 237	162	606	717	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
93. 00	04050 CLI NI C	84, 284	150	2	2, 139	0	93.00
93. 01	04950 BI C	0	0	0	0	0	93. 01
93. 05	04954 PODI ATRY	0	0	0	0	0	93. 05
05.00	OTHER REIMBURSABLE COST CENTERS		ما				05 00
	09500 AMBULANCE SERVI CES	0 0	0	0		0	95.00
101.00	D10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	J O	0	l 0	U U	U	101.00
116 00	011600 HOSPI CE	l ol	0	0	ol		116. 00
118. 00		445, 775	2, 220			11, 344	
110.00	NONREI MBURSABLE COST CENTERS	445,775	2, 220	3, 331	11, 101	11, 544	1110.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	0	0	Ö	o		191.00
	1 19101 FMH DIAGNOSTIC CENTER	o	0	Ö			191. 01
	2 19102 WELLNESS	30, 171	0	0	766		191. 02
192.00	19200 PHYSICIANS' PRIVATE OFFICES	4, 108	24	55	104	0	192.00
192. 0°	1 19201 RFE	0	0	0	0	0	192. 01
192. 02	2 19202 MARKETI NG	4, 330	25	0	110	0	192. 02
192.03	3 19203 FOUNDATI ON	4, 678	27	0	119	0	192. 03
	5 19206 HEART CENTER	3, 129	18	0	79		192. 06
	7 19207 WVCP	69, 958	0	11	1, 747		192. 07
	B 19208 OCCUPATI ONAL MED	0	0	0	0		192. 08
	19210 HOSPI TALI ST	0	0	0			192. 10
	07950 OTHER NONREI MBURSABLE COST CENTERS	32, 374	0	0			194.00
	1 07951 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194. 01
200.00		_[	_:	_	_	_	200.00
201.00		0	0 244	0	0	10 700	201.00
202. 00	TOTAL (sum lines 118 through 201)	594, 523	2, 314	3, 417	14, 512	19, 739	202. 00

| Peri od: | Worksheet B | From 10/01/2018 | Part | I | To 07/15/2019 | Date/Time Prepared: Provider CCN: 15-0064

			То	07/15/2019	Date/Time Pre 12/18/2019 2:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	44 piii
· ·		ADMI NI STRATI O	SERVICES &		RECORDS &	
	11.00	N 13. 00	SUPPLY 14. 00	15. 00	16. 00	
GENERAL SERVI CE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00   00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
7. 01   00701   OPERATION OF PLANT						7. 01
8. 00   00800 LAUNDRY & LINEN SERVICE						8.00
9. 00   00900  HOUSEKEEPI NG 10. 00   01000  DI ETARY						9. 00 10. 00
11. 00   01100   CAFETERI A	26, 785					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	754					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	175	0	17, 836			14.00
15. 00 01500 PHARMACY	520		0	21, 667		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	1, 695	0	0	0	29, 494	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.470	T ====		ما	2 522	
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	3, 178		0	0	3, 502	30. 00 31. 00
40. 00   04000 SUBPROVI DER -   1 PF	1, 496	203	0	0	767 0	40.00
41. 00   04100   SUBPROVI DER	0	0	0	0	0	41.00
42. 00   04200   SUBPROVI DER	0	o	Ö	o	0	42.00
43. 00   04300 NURSERY	44	8	0	0	14	1
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	958		0	0	1, 288	
54. 00   05400  RADI OLOGY-DI AGNOSTI C 60. 00   06000  LABORATORY	1, 415		0	0	6, 073	1
65. 00   06500   RESPI RATORY THERAPY	1, 396 713	125	0	0	4, 722 1, 148	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	597	105	0	0	406	1
69. 00 06900 ELECTROCARDI OLOGY	0	0	Ö	o	0	69.00
69. 01   06901 CARDI AC REHAB	347	61	0	O	165	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	O	17, 836	0	308	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	252	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	21, 667	2, 364	73. 00
91.00 OUTPATIENT SERVICE COST CENTERS 91.00 O9100 EMERGENCY	2, 220	390	0	ol	5, 027	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,220	370	J	ď	5,027	92.00
93. 00   04050   CLI NI C	5, 387	947	0	0	3, 458	1
93. 01   04950   BI C	0	0	0	0	0	
93. 05   04954   PODI ATRY	0	0	0	0	0	93. 05
OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVICES	1 0		0	٥	0	05.00
101. 00 10100 HOME HEALTH AGENCY	0 0		0	0		95. 00 101. 00
SPECIAL PURPOSE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		101.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	20, 895	3, 120	17, 836	21, 667	29, 494	118. 00
NONREI MBURSABLE COST CENTERS			0	ما		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0	0	0		190. 00 191. 00
191. 01 19101 FMH DI AGNOSTI C CENTER	0	0	0	o		191.00
191. 02 19102 WELLNESS	305		Ö	o		191.02
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	250		0	o		192.00
192. 01 19201 RFE	0	0	0	0		192. 01
192. 02 19202 MARKETI NG	0	0	0	0		192. 02
192. 03 19203 FOUNDATI ON 192. 06 19206 HEART CENTER			0	0		192. 03 192. 06
192. 07 19207 WVCP	5, 335	0	0	0		192.00
192. 08 19208 OCCUPATI ONAL MED	0,333	l ől	Ö	ő		192. 08
192. 10 19210 HOSPI TALI ST	0	o	O	o		192. 10
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	O		194. 00
194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0	0	194. 01
200.00 Cross Foot Adjustments	_	_			^	200.00
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118 through 201)	26, 785	3, 120	17, 836	21, 667		201. 00 202. 00
202. 00   TOTAL (Sum TIMES TTO THE OUGH 201)	20, 763	3, 120	17,030	21,007	∠۶, 474	1202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0064 Peri od: Worksheet B From 10/01/2018 Part II 07/15/2019 Date/Time Prepared: 12/18/2019 2:44 pm Cost Center Description Subtotal Intern & Total Resi dents Cost & Post Stepdown Adj ustments 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00701 OPERATION OF PLANT 7.01 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11 00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 104, 773 104, 773 30.00 03100 INTENSIVE CARE UNIT C 31 00 31 00 63,072 63,072 40.00 04000 SUBPROVI DER - I PF 0 0 0 40.00 04100 SUBPROVI DER - I RF 0 0 0 41.00 41.00 04200 SUBPROVI DER 0 42.00 42.00 0 0 04300 NURSERY 43.00 29, 685 0 29, 685 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 136, 781 136, 781 50.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 109, 396 0 109, 396 54 00 06000 LABORATORY 55, 949 55, 949 60.00 0 60.00 65.00 06500 RESPIRATORY THERAPY 26, 126 0 26, 126 65.00 06600 PHYSI CAL THERAPY 66.00 43,607 0 43,607 66.00 06900 ELECTROCARDI OLOGY 69 00 0 69 00 69.01 06901 CARDI AC REHAB 20.201 0 20, 201 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 18, 144 0 18, 144 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1.121 0 1.121 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 24, 031 0 24, 031 73.00 OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY 91.00 91.00 67,033 67,033 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 04050 CLI NI C 93.00 93.00 177.655 0 177, 655 93.01 04950 BI C 0 93.01 93.05 04954 PODI ATRY 0 Ω 0 93.05 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95 00 0  $\cap$  $\cap$ 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0 Ω 0 116 00 SUBTOTALS (SUM OF LINES 1 through 117) 877, 574 118.00 0 877, 574 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 0 191. 00 19100 RESEARCH 0 191. 00 O 0 191. 01 19101 FMH DIAGNOSTIC CENTER 603 603 191.01 191. 02 19102 WELLNESS 58, 334 0 58, 334 191.02 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 8, 172 0 8, 172 192. 01 19201 RFE 0 192.01 8, 574 192. 02 19202 MARKETI NG 8,574 192.02 192. 03 19203 FOUNDATI ON 8, 934 8, 934 192.03 192.06 19206 HEART CENTER 5, 975 5, 975 192.06 0 192. 07 19207 WVCP 157, 697 0 157, 697 192.07 192. 08 19208 OCCUPATIONAL MED 192.08 192. 10 19210 HOSPI TALI ST 1.705 0 1.705 192. 10 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 194.00 61, 303 61, 303 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 445 445 194.01 200.00 Cross Foot Adjustments 0 0 0 200.00 201 00 Negative Cost Centers 0 201 00 0 202.00 TOTAL (sum lines 118 through 201) 1, 189, 321 1, 189, 321 202.00

CAPITAL   RELECTIONS   SUBMINISTRATION   CAPITAL   CAP					'	o 07/15/2019	Date/lime Pre 12/18/2019 2:	
Cost Center Description			CAPI TAL	<b>'</b>			127 107 2017 21	
COUARE FEET   DEPARTMENT   CROROSS   CRORE   CACCUM. COST)   COUARE FEET								
BENERAL SERVICE COST_CENTERS   1.00		Cost Center Description			Reconciliatio			
GENERAL SERVICE COST CENTERS   1.00			(SQUARE FEET)		n			
SALARIES    1,00						(ACCUM. COST)	(SQUARE FEET)	
				•				
CENTRAL SERVICE COST CENTERS								
1.00			1.00	4. 00	5A	5. 00	7. 00	
4.00   OO400   EMPLOYEE BENEFITS DEPARTMENT   1, 591   14, 113, 576   1, 200   00   00   00   00   00   00   00			100 500					1
5.00   OSSOO ADMINISTRATIVE & GENERAL   25.681   1,452,473   -6,857,427   19,966,342   77,01   OZOO OPERATINO OF PLANT   203,072   268,095   0   0,244,973   179,17   7,01   OZOO OPERATINO OF PLANT   0   0   0   0   0,385,567   2,80   0,900 OLAUNDRY & LINEN SERVICE   441   0   0   0   0   385,567   2,80   0,900 ODE LAUNDRY & LINEN SERVICE   441   0   0   0   385,567   2,80   0,900 ODE LAUNDRY & LINEN SERVICE   440   0   0   385,567   2,80   0   0,900 ODE LAUNDRY & LINEN SERVICE   440   0   0   385,567   2,80   0   0   0   0   0   0   0   0   0			1 1	14 110 57/				1.00
7.00   00700   00PATI 10N OF PLANT   203,072   268,095   0   1,244,973   179,17   10701   00701   00PATI 10N OF PLANT   0   0   0   0   0   0   0   0   0					1	10 0// 242		4.00
7. 01   00701   00FATI   00   0   0   0   0   0   0   0   0			1		1		170 170	5.00
B.00   00800   LANDRY & LINEN SERVICE		· ·	1	268, 095	1			1
0,000   000000   HOUSEKEEPING   2, 021   347, 554   0   474, 859   2, 02   11. 00   01100   DETARY   2, 283   199, 940   0   385, 567   2, 82   11. 00   01100   CAFETRIA   4, 097   184, 509   0   215, 244   4, 097   14. 00   01400   CAFETRIA   2, 267   56, 259   0   172, 131   2, 68   14. 00   01400   CENTRAL   SERVICES & SUPPLY   2, 687   56, 259   0   172, 131   2, 68   15. 00   01500   PHARMACY   2, 260   241, 763   0   1, 229, 859   2, 00   16. 00   10100   HEDICAL   RECORDS & LI BRARY   3, 897   624, 263   0   783, 428   3, 89   16. 00   01500   MEDICAL   RECORDS & LI BRARY   3, 897   624, 263   0   783, 428   3, 89   17. 00   01500   MEDICAL   RECORDS & LI BRARY   3, 897   624, 263   0   783, 428   3, 89   18. 00   01500   MEDICAL   RECORDS & LI BRARY   3, 897   624, 263   0   783, 428   3, 89   18. 00   01500   MEDICAL   RECORDS & LI BRARY   3, 897   624, 263   0   783, 428   3, 89   18. 00   01500   MEDICAL   RECORDS & LI BRARY   3, 897   624, 263   0   783, 428   3, 89   19. 00   01500   MEDICAL   RECORDS & LI BRARY   3, 897   624, 263   0   0   0   0   0   11. 00   03000   ADULTS & PEDIATRIC SCOTT   CENTERS   12, 344   1, 459, 264   0   2, 070, 571   12, 34   11. 00   01500   MEDICAL   RECORDS & LI BRARY   4, 662   14, 553   0   32, 998   4, 66   11. 00   01100   MEDICAL   ME		1	1 -1	C			0	
10.00   01000   0150			1	247 554				8.00
11. 00   01100   CAFETERIA   4,097   184,509   0   215,424   4,09   140,00   140,0		l .	1 1		1			9.00
13. 00   01300   NURSING ADMINISTRATION   0   492, 426   0   586, 539   172, 131   2, 68   15. 00   01500   PHARMACY   2, 660   241, 763   0   1, 229, 589   2, 60   16. 00   1600   MEDICAL RECORDS & LIBRARY   2, 660   241, 763   0   1, 229, 589   2, 60   16. 00   1600   MEDICAL RECORDS & LIBRARY   3, 897   624, 263   0   783, 428   3, 89   10, 200   10			1 1		1			1
14. 00   01400   CENTRAL SERVICES & SUPPLY   2, 687   56, 289   0   172, 131   2, 88     15. 00   01500   PHADMACY   2, 600   241, 763   0   1, 229, 589   2, 60     16. 00   01600   MEDICAL RECORDS & LI BRARY   3, 897   624, 263   0   783, 428   3, 89     1		l .	1		1		4,097	1
15. 00   01500   PHARMACY			-		1			
16.00   01600   MEDICAL RECORDS & LIBRARY   3, 897   624, 263   0   783, 428   3, 89			1		1			
IMPATI ENT ROUTI NE SERVI CE COST CENTERS   12, 344			1	·	1			1
30.00   03000   ADULTS & PEDIATRICS   12, 344   1, 459, 264   0   2, 070, 571   12, 34			3, 097	024, 203	0	703, 420	3, 097	10.00
131 00			12 244	1 450 244		2 070 571	12 244	30.00
A0. 00   04000   SUBPROVI DER - I PF		l .	1		1			1
A1-00   04100   SUBPROVI DER		l .	1	003, 043	1	001, 043	0, 802	1
A2.00   04200   SUBPROVI DER   0 0 0 0 0 32 98		l .	0		'l š	0	0	
43.00   04300   NURSERY   4, 662			0		1	-	0	
ANCILLARY SERVICE COST CENTERS			1 662	1/ 522	1	_	_	1
50.00			4,002	14, 555	0	32, 770	4,002	43.00
54.00   05400   RADI OLOGY - DI AGNOSTI C   14, 989   616, 162   0   1, 646, 303   14, 98			20.868	403 714	1	512 704	20. 868	50.00
60. 00   06000   LABORATORY   7, 140   458, 565   0   1, 136, 432   7, 146   50. 00   06500   RESPI RATORY THERAPY   3, 586   280, 410   0   363, 350   3, 586   3, 586   280, 410   0   362, 355   3, 586   3, 586   280, 410   0   328, 757   6, 44   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   0   0   0					1	·		1
65. 00   06500   RESPIRATORY THERAPY   3, 586   280, 410   0   363, 350   3, 58   66. 00   06600   PHYSI CAL THERAPY   6, 448   251, 948   0   328, 757   6, 44   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   69. 01   06901   CARDI AC REHAB   2, 982   137, 155   0   184, 213   2, 98   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   74. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   75. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   76. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   77. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   78. 00   04950   BI C   0   0   0   0   79. 00   04950   BI C   0   0   0   0   79. 00   04950   BI C   0   0   0   79. 00   04950   BI C   0   0   0   79. 00   04950   ABBULRANCE SERVI CES   0   0   0   0   79. 00   04950   ABBULRANCE SERVI CES   0   0   0   0   79. 00   0500   ABBULRANCE SERVI CES   0   0   0   0   79. 00   00   0   0   79. 00   00   0   0   79. 00   00   0   0   79. 00   00   0   0   79. 00   00   0   0   79. 00   00   0   79. 00   00   0   0   79. 00   00   00   79. 00   00   00   79. 00   00   00   79. 00   00   00   7					1			1
66. 00   06600   PHYSI CAL THERAPY   6, 448   251, 948   0   328, 757   6, 44   69. 00   06900   CARDIA CREHAB   2, 982   137, 155   0   184, 213   2, 98   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   231, 111   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   74. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   75. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   76. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   77. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   78. 00   09100   DEMERGENCY   8, 510   979, 935   0   1, 234, 368   8, 510   79. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   79. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   79. 00   09400   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   79. 00   09500   AMBULANCE SERVI CES   0   0   0   0   0   70   O9500   AMBULANCE SERVI CES   0   0   0   0   0   70   O0   00   00   0   70   O0   00   00   0   70   O0		l .	1 1		1		-	1
69. 00   06900   CARDI AC REHAB   2, 982   137, 155   0   184, 213   2, 98   137, 155   0   184, 213   2, 98   137, 155   0   184, 213   2, 98   137, 155   0   184, 213   2, 98   137, 155   0   0   0   0   0   0   0   0   0		l .	1		1			1
69. 01   06901   CARDI AC REHAB   2, 982   137, 155   0   184, 213   2, 98   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0			0, 440	231, 740		320, 737	0, 440	1
71. 00			2 982	137 155		184 213		1
72. 00		· ·	2, 702	137, 130		104, 213	2, 702	1
73. 00		1				231 111	0	1
OUTPATIENT SERVICE COST CENTERS   91. 00   09100  EMERGENCY   92. 00   09200  OBSERVATION BEDS (NON-DISTINCT PART)   93. 00   04050  CLINIC   25, 402   3, 110, 602   0   1, 726, 623   25, 402   3, 110, 602   0   1, 726, 623   25, 402   3, 110, 602   0   0   0   0   0   0   0   0   0							0	1
91. 00			<u> </u>		,,		0	75.00
92. 00			8 510	979 935		1 234 368	8 510	91.00
93. 00		l .	0,010	777,700	ή	1, 201, 000	0,010	92.00
93. 01			25, 402	3, 110, 602		1, 726, 623	25, 402	
93. 05			1	0, 1.10, 002	1		0	
OTHER REIMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O			-	C			0	
95. 00			<u> </u>		,1			70.00
101.00			0	C	) 0	0	0	95.00
SPECIAL PURPOSE COST CENTERS   SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   364,693   12,262,695   -6,857,427   16,150,962   134,34					1			101.00
116. 00			-					
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 364, 693 12, 262, 695 -6, 857, 427 16, 150, 962 134, 34 NONREI MBURSABLE COST CENTERS  190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	C	0	0	0	116.00
NONRE   MBURSABLE COST CENTERS   190. 00 19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   0   0   0   0			364, 693	12, 262, 695	-6, 857, 427	16, 150, 962	134, 349	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	NONR							1
191. 01   19101   FMH DI AGNOSTI C CENTER 0 113, 603 0 150, 543   191. 02   19102   WELLNESS 9, 093 59, 037 0 176, 789 9, 09 192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES 1, 238 1, 232 0 9, 528 1, 23 192. 01   19201   RFE 0 0 0 0 167			0	C	0	0	0	190.00
191. 01   19101   FMH DI AGNOSTI C CENTER 0 113, 603 0 150, 543   191. 02   19102   WELLNESS 9, 093 59, 037 0 176, 789 9, 09 192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES 1, 238 1, 232 0 9, 528 1, 23 192. 01   19201   RFE 0 0 0 0 167			O	C	) 0	0		191.00
191. 02     19102     WELLNESS     9, 093     59, 037     0     176, 789     9, 09       192. 00     19200     PHYSI CI ANS'     PRI VATE OFFI CES     1, 238     1, 232     0     9, 528     1, 23       192. 01     19201     RFE     0     0     0     167			O	113, 603	s  c	150, 543		191.01
192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES			9, 093		1			191.02
192. 01   19201   RFE   0   0   0   167			1		1			192.00
			1		1			192. 01
192. 02   19202   MARKETI NG   1, 305   49, 632   0   80, 642   1, 30			1, 305	49, 632	2 0			192. 02
192. 03   19203   FOUNDATI ON   1, 410   0   0   4, 095   1, 410	192.03 1920	3 FOUNDATI ON	1, 410	C	0	4, 095	1, 410	192.03
		l .		C	) 0			192.06
			1 1	1, 535, 086	o			192. 07
			0	C	) 0			192.08
			0	C	) 0			192. 10
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 9, 757 0 0 28, 336 9, 75	194. 00 0795	O OTHER NONREIMBURSABLE COST CENTERS	9, 757	C	) 0	·		194.00
			0	92, 291				194. 01
200.00 Cross Foot Adjustments	200.00							200.00
201.00 Negative Cost Centers								201.00
			1, 189, 321	1, 691, 465	5	6, 857, 427	1, 672, 558	
Part I)								1
	203. 00		2. 904162	0. 119847	'	0. 343449	9. 334565	203.00
	204.00						594, 523	
Part II)								
205.00 Unit cost multiplier (Wkst. B, Part 0.000327 0.003759 3.31804	205. 00	Unit cost multiplier (Wkst. B, Part		0. 000327	'	0. 003759	3. 318040	205.00
		11)						1

Health Financial Systems F.	AYETTE REGIONAL	HEALTH SYSTEM	<u> </u>	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 10/01/2018		
				To 07/15/2019	Date/Time Pre 12/18/2019 2:	
Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	PLANT	
	1. 00	4. 00	5A	5. 00	7. 00	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems	FAYETTE REGIONAL				u of Form CMS-2	
COST A	NLLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 10/01/2018 o 07/15/2019	Worksheet B-1 Date/Time Pre	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	12/18/2019 2: CAFETERIA (MAN HOURS)	44 pm
		7. 01	LAUNDRY) 8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	, ,,,,,,	0.00	7.00	101 00	111.00	
1. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00	00100 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	121, 716 491 2, 021 2, 823 4, 097 0 2, 687 2, 600 3, 897	63, 248 0 6, 817 0 0 0	172, 341 2, 823 4, 097 0 2, 687 2, 600 3, 897	64, 178 0 0 0 0 0	414, 938 11, 673 2, 718 8, 051 26, 265	13. 0 14. 0 15. 0
30. 00	O3000 ADULTS & PEDIATRICS	12, 344	16, 046	12, 344	33, 575	49, 233	30.0
31. 00 40. 00 41. 00 42. 00 43. 00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	8, 802 0 0 4, 662		8, 802 0 0 0 4, 662	3, 309 0 0 0	23, 182 0 0 0 685	31. 00 40. 00 41. 00 42. 00
50. 00	05000 OPERATING ROOM	20, 868		20, 868	0	14, 835	
54. 00 60. 00	05400   RADI OLOGY-DI AGNOSTI C   06000   LABORATORY	14, 989 7, 140		14, 989 7, 140	0 0	21, 921 21, 622	
55.00	06500 RESPIRATORY THERAPY	3, 586		3, 586	0	11, 051	
56. 00 59. 00	O6600  PHYSI CAL THERAPY   O6900  ELECTROCARDI OLOGY	6, 448	7, 291	6, 448 0	0	9, 255 0	1
59. 01	06901 CARDI AC REHAB	2, 982	535	2, 982	0	5, 380	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
0.00	OUTPATIENT SERVICE COST CENTERS			<u> </u>	۷,		70.0
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 510		8, 510	0	34, 386	92.0
93. 00 93. 01	04050   CLI NI C   04950   BI C	7, 873	40	25, 402 0	0	83, 437 0	
93. 05	04954 PODI ATRY	0	0	0	0	0	93.0
)5 NN	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES	0	0	0	O	0	95. 0
	10100 HOME HEALTH AGENCY	0	0	0	0		101.0
	SPECIAL PURPOSE COST CENTERS						
16. 00  18. 00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1 through 117	0 7) 116, 820					116.0
110.00	NONREI MBURSABLE COST CENTERS	7)   110, 620	02, 024	131,037	30, 004]	323, 074	1110.0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	_	0	0		190. 0
	19100 RESEARCH  19101 FMH DIAGNOSTIC CENTER	0	0	0	0		191. 0 191. 0
	19102 WELLNESS	Ö	Ö	9, 093	0	4, 728	
	19200 PHYSICIANS' PRIVATE OFFICES	1, 238	1, 019		0	3, 869	
	19201  RFE  19202  MARKETI NG	1, 305	0	0 1, 305	0		192. 0
	19203 FOUNDATION	1, 410		1, 410	Ö		192.0
	19206 HEART CENTER	943		943	0		192.0
	19207 WVCP  19208 OCCUPATIONAL MED	0	205	20, 745 0	27, 294	82, 647	192. 0
	19210 HOSPI TALI ST	0	0	0	0		192. 1
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	5, 770	0		194.0
94. 01 200. 00	O7951 OTHER NONREIMBURSABLE COST CENTERS   Cross Foot Adjustments	0	0	0	0	0	194. 0 200. 0
01. 00	1 1						201. 0
02.00		826, 871	133, 941	670, 544	588, 939	371, 429	202. 0
03. 00 04. 00		6. 793445 2, 314		3. 890798 14, 512	9. 176649 19, 739	0. 895143 26, 785	
05. 00	Part II)	0. 019011	0. 054025	0. 084205	0. 307566		
206. 00							206. 0
	(per Wkst. B-2)						
207. OC	INAME UNIT COST MULTIPLIAR (WKST 1)	1	ı	1			207.00

0031 A	LLOCATION - STATIS	TICAL BASIS		Provi der CO	CN: 15-0064 F	Peri od:	Worksheet B-1
							Date/Time Prepared 12/18/2019 2:44 pm
	Cost Center	Descri pti on	NURSI NG ADMI NI STRATI O	CENTRAL SERVICES &	PHARMACY (100%)	MEDICAL RECORDS &	
			N (FTE'S)	SUPPLY (100%)		LI BRARY (GROSS	
					15.00	CHARGES)	
	GENERAL SERVICE CO	ST CENTERS	13. 00	14. 00	15. 00	16. 00	
1. 00 4. 00	00100 CAP REL COST 00400 EMPLOYEE BEN						1. C 4. C
5. 00	00500 ADMI NI STRATI						5.0
7. 00 7. 01	00700 OPERATION OF 00701 OPERATION OF						7. C 7. C
8.00	00800 LAUNDRY & LI	NEN SERVICE					8. C
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. C 10. C
11.00	01100 CAFETERI A						11. C
13. 00 14. 00	01300 NURSING ADMI 01400 CENTRAL SERV		18, 091	100			13. C
15.00	01500 PHARMACY		O	0	100		15. C
16. 00	01600 MEDICAL RECO	RDS & LIBRARY SERVICE COST CENTERS	0	0	(	59, 150, 507	16.0
30.00	03000 ADULTS & PED	I ATRI CS	3, 239	0	(	, . ,	30.0
31. 00 40. 00	03100 I NTENSI VE CA 04000 SUBPROVI DER		1, 525	0	(	.,,	31. C 40. C
41.00	04100 SUBPROVI DER		o	0	(	o	41. C
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY		0 45	0	(		42. C 43. C
	ANCILLARY SERVICE			-			
50. 00 54. 00	05000 OPERATI NG RO 05400 RADI OLOGY-DI		976 1, 442	0	(		50. C 54. C
60.00	06000 LABORATORY		1, 423	0	C	9, 462, 729	60.0
65. 00 66. 00	06500 RESPIRATORY 06600 PHYSICAL THE		727 609	0	(	_, -,,	65. C
69.00	06900 ELECTROCARDI		0	0	(	0	69.0
69. 01 71. 00	06901 CARDI AC REHA 07100 MEDI CAL SUPP	LIES CHARGED TO PATIENTS	354	0 100	(	331, 372 616, 943	69. C 71. C
	07200 I MPL. DEV. C 07300 DRUGS CHARGE		0	0	100		72. 0 73. 0
73.00	OUTPATIENT SERVICE		l ol	U	100	J 4, 737, 542	/3.0
	09100 EMERGENCY	BEDS (NON-DISTINCT PART)	2, 262	0	C	10, 074, 758	91. C 92. C
93.00	04050 CLI NI C	DEDS (NON DISTINCT PART)	5, 489	0	(	6, 930, 646	93.0
93. 01 93. 05	04950 BI C 04954 PODI ATRY		0	0	(		93. C 93. C
	OTHER REIMBURSABLE		-	٥,			
	09500 AMBULANCE SE		0	0		0 0	95. C 101. C
	SPECIAL PURPOSE CO			-			
116.00	11600 HOSPI CE SUBTOTALS (S	UM OF LINES 1 through 117)	18, 091	0 100	100		116. C 118. C
100.00	NONRE! MBURSABLE CO	ST CENTERS					
	19100 RESEARCH	, COFFEE SHOP & CANTEEN	0	0	(		190. C 191. C
	19101 FMH DI AGNOST	IC CENTER	0	0	(		191. C 191. C
	19102 WELLNESS 19200 PHYSI CI ANS'	PRI VATE OFFI CES	0	0	(		191.0
	19201 RFE 19202 MARKETI NG		0	0	(	-	192. 0 192. 0
	19203 FOUNDATION		0	0	(		192. 0
	19206 HEART CENTER 19207 WVCP		0	0	(		192. 0 192. 0
192.08	19208 OCCUPATI ONAL	MED	0	0	(		192. C
	19210 HOSPI TALI ST	MBURSABLE COST CENTERS	0	0	(	0	192. 1 194. 0
194.01	07951 OTHER NONREI	MBURSABLE COST CENTERS	Ö	Ō	Č	o o	194. C
200. 00 201. 00	l I						200. 0 201. 0
202.00	Cost to be a	llocated (per Wkst. B,	798, 434	287, 473	1, 711, 146	1, 154, 020	202. 0
203. 00	Part I) Unit cost mu	Itiplier (Wkst. B, Part I)	44. 134321	2, 874. 730000	17, 111. 460000	0. 019510	203.0
204. 00	Cost to be a	llocated (per Wkst. B,	3, 120	17, 836	21, 667	1	204. 0
205. 00		Itiplier (Wkst. B, Part	0. 172461	178. 360000	216. 670000	0. 000499	205. 0
		ent amount to be allocated					206. 0

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM	l	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-0064	Peri od:	Worksheet B-1	
				From 10/01/2018 To 07/15/2019	Date/Time Pre 12/18/2019 2:	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
	ADMI NI STRATI O	SERVICES &	(100%)	RECORDS &		
	N	SUPPLY		LI BRARY		
	(FTE'S)	(100%)		(GROSS		
				CHARGES)		
	13. 00	14. 00	15.00	16.00		
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems F	AYETTE REGIONAL	HEALTH SYSTEM	1	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	1	Period: From 10/01/2018 Fo 07/15/2019		pared:
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1, 00	2, 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 694, 831		3, 694, 83	1 0	3, 694, 831	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 521, 451		1, 521, 45	0	1, 521, 451	31.00
40. 00   04000   SUBPROVI DER - 1 PF	0			0	0	40.00
41. 00   04100   SUBPROVI DER - I RF	0			0	0	41.00
42. 00   04200   SUBPROVI DER	0			0	0	42.00
43. 00 04300 NURSERY	140, 796		140, 796	0	140, 796	43.00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	1, 225, 538		1, 225, 538	3 0	1, 225, 538	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 851, 317		2, 851, 31	7 0	2, 851, 317	54.00
60. 00   06000   LABORATORY	1, 936, 448		1, 936, 448	3 0	1, 936, 448	60.00
65. 00 06500 RESPI RATORY THERAPY	646, 809	0	646, 809	9 0	646, 809	65.00
66. 00 06600 PHYSI CAL THERAPY	637, 225	0	637, 22	5 0	637, 225	66.00
69. 00   06900   ELECTROCARDI OLOGY	0			0	0	69.00
69. 01   06901   CARDI AC REHAB	335, 215		335, 21	5 0	335, 215	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	299, 510		299, 510	0	299, 510	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	320, 327		320, 32	7 0	320, 327	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	1, 803, 575		1, 803, 57	0	1, 803, 575	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	2, 179, 587		2, 179, 58		2, 179, 587	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	688, 163		688, 163		688, 163	
93. 00  04050   CLI NI C	3, 161, 308		3, 161, 308	5, 425	3, 166, 733	
03 01 04050 DLC	_	1	1		0	02 01

21, 442, 100 688, 163

20, 753, 937

0

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0

21, 442, 100 688, 163

20, 753, 937

0

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0

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5, 425

5, 425

0

ol

0 95.00

0 116.00 21, 447, 525 200.00 688, 163 201.00 20, 759, 362 202.00

93.01

93.05 0

0 101.00

93. 01 04950 BIC

116. 00 11600 HOSPI CE

04954 PODI ATRY

95. 00 09500 AMBULANCE SERVICES 101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

93.05

200. 00 201. 00

202.00

Peri od: Worksheet C From 10/01/2018 Part I To 07/15/2019 Date/Time Prepared:

Title XVII   Hospital   PPS						10 077 107 2017	12/18/2019 2:	
Cost Center Description				Title	: XVIII	Hospi tal		
NPATIENT ROUTINE SERVICE COST CENTERS		·		Charges				
INPATIENT ROUTINE SERVICE COST CENTERS		Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
INPATIENT ROUTINE SERVICE COST CENTERS					+ col. 7)	Ratio	I npati ent	
INPATIENT ROUTINE SERVICE COST CENTERS							Ratio	
30.00			6. 00	7. 00	8. 00	9. 00	10.00	
31.00   03100   INTENSIVE CARE UNIT	I	NPATIENT ROUTINE SERVICE COST CENTERS						
40.00   04000   SUBPROVI DER - IPF	30.00	03000 ADULTS & PEDIATRICS	5, 210, 639		5, 210, 63	9		30.00
41.00   04100   SUBPROVI DER - I RF   0   0   0   0   42.00   42.00   04200   SUBPROVI DER   0   0   0   0   42.00   42.00   42.00   42.00   42.00   42.00   42.00   42.00   42.00   42.00   43.00   42.00   43.00   4	31.00	03100 INTENSIVE CARE UNIT	1, 537, 181		1, 537, 18	1		31.00
42. 00   04200   SUBPROVI DER   0   27,583   27583   43.00   04300   NURSERY   27,583	40.00	04000 SUBPROVI DER - I PF	o			0		40.00
43. 00	41.00	04100 SUBPROVI DER - I RF	o			0		41.00
ANCILLARY SERVICE COST CENTERS   131, 995   2, 450, 112   2, 582, 107   0. 474627   0. 000000   50. 00   0. 000000   0. 00000   0. 00000   0. 000000   0. 00000   0. 00000   0. 00000   0. 00000   0. 000000   0. 00000   0. 000000	42.00	04200 SUBPROVI DER	O			0		42.00
50. 00   05000   OPERATI NG ROOM   131, 995   2, 450, 112   2, 582, 107   0. 474627   0. 000000   50. 00   54. 00   65400   RADI OLOGY-DI AGNOSTI C   626, 898   11, 586, 254   12, 213, 152   0. 233463   0. 000000   54. 00   60	43.00	04300 NURSERY	27, 583		27, 58	3		43.00
54. 00	Α	NCILLARY SERVICE COST CENTERS						İ
60. 00   06000   LABORATORY   1,158,204   8,304,525   9,462,729   0.204639   0.000000   60.00   65. 00   06500   RESPI RATORY THERAPY   395,162   1,906,325   2,301,487   0.281040   0.000000   65.00   66. 00   06600   PHYSI CAL THERAPY   13,129   800,434   813,563   0.783252   0.000000   66.00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0.000000   0.000000   0.000000   69. 01   06901   CARDI AC REHAB   0   331,372   331,372   1.011597   0.000000   69. 01   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   311,881   305,062   616,943   0.485474   0.000000   71.00   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   910   503,487   504,397   0.635069   0.000000   72.00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1,484,068   3,253,474   4,737,542   0.380698   0.000000   73.00   79. 00   09100   EMERGENCY   804,181   9,270,577   10,074,758   0.216341   0.000000   91.00   79. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   1,806,408   1,806,408   0.380957   0.000000   93.00   79. 01   04950   BI C   0   0   0   0.000000   0.000000   79. 02   04950   BI C   0   0   0   0.000000   0.000000   79. 04950   MBULANCE SERVI CES   0   0   0   0.000000   0.000000   79. 00   01100   HOME HEALTH AGENCY   0   0   0   0.000000   79. 01   0100   HOME HEALTH AGENCY   0   0   0   0.000000   79. 0201.00   Less Observati on Beds   011,703,245   47,447,262   59,150,507   79. 00   0201.00   Less Observati on Beds   0201.00   79. 00   0201.00   Call Structions   0.000000   0.000000   79. 00   0201.00   0.000000   0.000000   79. 00   0.000000   0.000000   79. 00   0.000000   0.000000   79. 00   0.000000   0.000000   79. 00   0.000000   79. 00   0.000000   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.000000   79. 00   0.0000000   79. 00   0.0	50.00	05000 OPERATING ROOM	131, 995	2, 450, 112	2, 582, 10	7 0. 474627	0.000000	50.00
65. 00   06500   RESPIRATORY THERAPY   395, 162   1, 906, 325   2, 301, 487   0. 281040   0. 000000   65. 00   66. 00   06600   PHYSI CAL THERAPY   13, 129   800, 434   813, 563   0. 783252   0. 000000   66. 00   69. 01   06901   CARDI AC REHAB   0   331, 372   331, 372   1. 011597   0. 000000   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   311, 881   305, 062   616, 943   0. 485474   0. 000000   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   910   503, 487   504, 397   0. 635069   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1, 484, 068   3, 253, 474   4, 737, 542   0. 380698   0. 000000   72. 00   73. 00   07100   EMERGENCY   804, 181   9, 270, 577   10, 074, 758   0. 216341   0. 000000   91. 00   74. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   1, 806, 408   1, 806, 408   0. 380957   0. 000000   93. 01   75. 00   04950   Bi C   0   0   0   0. 000000   0. 000000   93. 01   75. 00   07500   AMBULANCE SERVI CES   0   0   0   0. 000000   0. 000000   93. 05   75. 00   0500   AMBULANCE SERVI CES   0   0   0   0. 000000   0. 000000   75. 00   0500   MBULANCE SERVI CES   0   0   0   0. 000000   0. 000000   0. 000000   75. 00   0500   OSSERVATI ON BEDS (SERVICES   0   0   0   0. 000000   0. 000000   0. 000000   75. 00   0500   AMBULANCE SERVI CES   0   0   0   0. 000000   0. 000000   0. 000000   75. 00   0500   AMBULANCE SERVI CES   0   0   0   0. 000000   0. 000000   0. 000000   75. 00   0500   0500   0500   0500   0. 000000   0.	54.00	05400 RADI OLOGY-DI AGNOSTI C	626, 898	11, 586, 254	12, 213, 15	2 0. 233463	0.000000	54.00
66. 00 06600 PHYSICAL THERAPY 13, 129 800, 434 813, 563 0. 783252 0. 000000 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0. 000000 0. 000000 69. 00 69. 00 06901 CARDI AC REHAB 0 331, 372 331, 372 1. 011597 0. 000000 69. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 311, 881 305, 062 616, 943 0. 485474 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 910 503, 487 504, 397 0. 635069 0. 000000 72. 00 07300 DRUGS CHARGED TO PATIENTS 1, 484, 068 3, 253, 474 4, 737, 542 0. 380698 0. 000000 73. 00 000000 DUTPATIENT SERVICE COST CENTERS 1, 484, 068 3, 253, 474 4, 737, 542 0. 380698 0. 000000 73. 00 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 1, 806, 408 1, 806, 408 0. 380957 0. 000000 92. 00 93. 00 04050 BIC 0. 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 1, 414 6, 929, 232 6, 930, 646 0. 456135 0. 000000 93. 00 04050 BIC 0. 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0. 000000 0. 000000 93. 01 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0. 000000 0. 000000 93. 01 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0. 000000 0. 000000 93. 01 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0. 000000 0. 000000 93. 01 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0. 000000 0. 000000 93. 01 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0. 000000 0. 000000 93. 01 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0. 000000 0. 000000 93. 01 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0. 000000 0. 000000 93. 01 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0. 000000 0. 000000 93. 01 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0. 000000 0. 000000 93. 01 000000 PSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0. 000000 0. 000000 93. 01 0000000000000000000000000000000000	60.00	06000 LABORATORY	1, 158, 204	8, 304, 525	9, 462, 72	9 0. 204639	0.000000	60.00
69. 00 06900   ELECTROCARDI OLOGY	65.00	06500 RESPIRATORY THERAPY	395, 162	1, 906, 325	2, 301, 48	7 0. 281040	0.000000	65.00
69. 01 06901 CARDI AC REHAB 0 331, 372 331, 372 1. 011597 0. 000000 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 311, 881 305, 062 616, 943 0. 485474 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 910 503, 487 504, 397 0. 635069 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 484, 068 3, 253, 474 4, 737, 542 0. 380698 0. 000000 73. 00  91. 00 09100 EMERGENCY 804, 181 9, 270, 577 10, 074, 758 0. 216341 0. 000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 1, 806, 408 1, 806, 408 0. 380957 0. 000000 92. 00 93. 01 04050 CLINI C 1, 414 6, 929, 232 6, 930, 646 0. 456135 0. 000000 93. 00 93. 01 04950 BI C 0 0 0 0 0. 000000 0. 000000 93. 01 93. 05 04954 PODIATRY 0 0 0 0 0. 000000 0. 000000 93. 05  09500 AMBULANCE SERVI CES 0 0 0 0 0 0. 000000 0. 000000 95. 00  101.00 SPECIAL PURPOSE COST CENTERS  116. 00 11600 HOSPI CE 0 0 0 0 0 0 0 0. 000000 0. 000000 0. 000000	66.00	06600 PHYSI CAL THERAPY	13, 129	800, 434	813, 56	3 0. 783252	0.000000	66.00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0.000000	69.00
72. 00	69. 01	06901 CARDI AC REHAB	O	331, 372	331, 37	2 1. 011597	0.000000	69. 01
73. 00   07300   DRUGS CHARGED TO PATIENTS   1,484,068   3,253,474   4,737,542   0.380698   0.000000   73.00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	311, 881	305, 062	616, 94	3 0. 485474	0.000000	71.00
OUTPATIENT SERVICE COST CENTERS   OUTPATIENT SERVICE COUTPATIENT SUBJECT SERVICE COUTPATIENT SERVICE COUTPATIENT SERVICE COUTPATIENT SUBJECT SUBJECT SERVICE COUTPATIENT SUBJECT S	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	910	503, 487	504, 39	7 0. 635069	0.000000	72.00
91. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	1, 484, 068	3, 253, 474	4, 737, 54	2 0. 380698	0.000000	73.00
92. 00	C	OUTPATIENT SERVICE COST CENTERS						1
93. 00	91.00	09100 EMERGENCY	804, 181	9, 270, 577	10, 074, 75	8 0. 216341	0.000000	91.00
93. 01	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	1, 806, 408	1, 806, 40	8 0. 380957	0.000000	92.00
93. 05   04954   PODI ATRY   O O O O O 0.000000   O.000000   93. 05	93.00	04050 CLI NI C	1, 414	6, 929, 232	6, 930, 64	6 0. 456135	0.000000	93.00
OTHER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   0   0   0   0   0.000000   0.000000   95. 00   101. 00   OUNDED COST CENTERS   0   0   0   0   0   0   0   0   0	93. 01	04950 BI C	o	0		0. 000000	0.000000	93. 01
95. 00	93. 05	04954 PODI ATRY	o	0		0. 000000	0.000000	93. 05
101.00	C	THER REIMBURSABLE COST CENTERS						1
SPECIAL PURPOSE COST CENTERS   116.00   11600   HOSPI CE   0   0   0   0   116.00   200.00   Subtotal (see i nstructions)   11,703,245   47,447,262   59,150,507   200.00   201.00   Less Observation Beds   201.00	95.00	9500 AMBULANCE SERVICES	0	0		0. 000000	0.000000	95.00
116. 00	101.001	0100 HOME HEALTH AGENCY	0	0		0		101.00
200.00 Subtotal (see instructions) 11,703,245 47,447,262 59,150,507 200.00 Less Observation Beds 200.00	S	SPECIAL PURPOSE COST CENTERS						
201.00 Less Observation Beds 201.00	116.001	1600 HOSPI CE	0	0		0		116.00
	200.00	Subtotal (see instructions)	11, 703, 245	47, 447, 262	59, 150, 50	7		200.00
202.00   Total (see instructions)   11,703,245   47,447,262   59,150,507   202.00	201.00	Less Observation Beds						201.00
	202. 00	Total (see instructions)	11, 703, 245	47, 447, 262	59, 150, 50	7	ĺ	202.00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-00	From 10/01/2018	Worksheet C Part I Date/Time Prepared: 12/18/2019 2:44 pm
	T: +1 o V/// / /	Heeni tel	DDC

NPATIENT ROUTINE SERVICE COST CENTERS   11.00   11.0						12/18/2019 2:	44 piii
NPATI ENT ROUTI NE SERVI CE COST CENTERS   11.00   11.00				Title XVIII	Hospi tal	PPS	
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   31.00   03100   INTENSI VE CARE UNIT   31.00   041.00   04000   SUBPROVIDER - I PF   40.000   04000   SUBPROVIDER - I RF   41.00   041.00		Cost Center Description					
NPATI ENT ROUTI NE SERVICE COST CENTERS   30.00   30.00   300   ADULTS & PEDIATRICS   31.00   31.00   31.00   INTENSI VE CARE UNIT   31.00   40.00							
30. 00   03000   ADULTS & PEDIATRICS   30. 00   03100   INTENSIVE CARE UNIT   31. 00   40. 00   04000   SUBPROVI DER - IPF   40. 00   41. 00   04100   SUBPROVI DER - IRF   42. 00   42.00   04200   SUBPROVI DER   42. 00   42.00   04200   SUBPROVI DER   47. 00   42.00   04200   SUBPROVI DER   42. 00   04300   NURSERY   42. 00   04300   NURSERY   43. 00   ANCILLARY SERVICE COST CENTERS   43. 00   ANCILLARY SERVICE COST CENTERS   50. 00   05000   OPERATI NG ROOM   0.474627   54. 00   05400   RADI OLLOGY-DI AGNOSTI C   0.233463   54. 00   06500   RESPI RATORY THERAPY   0.204639   65. 00   06500   RESPI RATORY THERAPY   0.204639   65. 00   06500   RESPI RATORY THERAPY   0.281040   65. 00   06900   ELECTROCARDI OLOGY   0.000000   69. 01   06900   ELECTROCARDI OLOGY   0.000000   69. 01   06901   CARDI AC REHAB   1.011597   69. 01   71. 00   7100   MEDICAL SUPPLIES CHARGED TO PATI ENTS   0.485474   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.485474   71. 00   73. 00   73.00   DRUGS CHARGED TO PATI ENTS   0.380698   73. 00   000000   0.3000   0.300957   92. 00   000000   0.300957   92. 00   000000   0.300950   93. 00   04050   CLI NIC   0.000000   0.300957   93. 00   04050   CLI NIC   0.000000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000			11. 00				
31.00   03100   INTENSIVE CARE UNIT							1
40. 00   04000   SUBPROVI DER - I PF   40. 00   41. 00   04100   SUBPROVI DER - I RF   42. 00   42. 00   04200   SUBPROVI DER   42. 00   43. 00   04200   SUBPROVI DER   43. 00   04200   SUBPROVI DER   43. 00   04300   NURSERY   43. 00   05000   0FERATI NG ROOM   0. 474627   55. 00   05000   0FERATI NG ROOM   0. 474627   56. 00   05000   0FERATI NG ROOM   0. 233463   54. 00   06. 00   06000   LABDRATORY   0. 204639   66. 00   06000   LABDRATORY   0. 204639   66. 00   06. 00							
41. 00   04100   SUBPROVI DER - IRF   41. 00   42. 00   04200   SUBPROVI DER   42. 00   43. 00   04300   NURSERY   43. 00   04300   NURSERY   43. 00   04300   NURSERY   43. 00   04300   NURSERY   43. 00   05.							31.00
42. 00   04200   SUBPROVI DER     42. 00	40.00 0400	00 SUBPROVI DER - I PF					40.00
43. 00	41.00 0410	00 SUBPROVI DER – I RF					41.00
ANCILLARY SERVICE COST CENTERS   50.00   500.00   OPERATTING ROOM   0.474627   50.00   500.00   OPERATTING ROOM   0.233463   55.00   60.00   50400   RADIO LOGY-DI AGNOSTIC   0.233463   55.00   60.00   CABORATORY   0.204639   60.00   65.00   CABORATORY   0.281040   65.00   66.00   OPERATORY THERAPY   0.281040   66.00   OPERATORY THERAPY   0.281040   66.00   OPERATORY THERAPY   0.281040   66.00   OPERATORY THERAPY   0.281040   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	42.00 0420	00 SUBPROVI DER					42.00
50. 00   05000   OPERATING ROOM   0.474627   50. 00   54. 00   05400   RADI OLOGY-DI AGNOSTI C   0.233463   54. 00   60. 00   06000   LABORATORY   0.204639   66. 00   65. 00   06500   RESPI RATORY THERAPY   0.281040   65. 00   66. 00   06600   PHYSI CAL THERAPY   0.783252   66. 00   66. 00   06600   PHYSI CAL THERAPY   0.783252   66. 00   69. 01   06900   ELECTROCARDI OLOGY   0.000000   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.485474   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0.485474   77. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.535069   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0.380698   73. 00   91. 00   09100   EMERGENCY   0.216341   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0.380957   92. 00   93. 01   04950   BI C   0.000000   93. 01   93. 05   04954   POID ATRY   0.000000   93. 01   95. 00   09500   AMBULANCE SERVI CES   0.000000   97. 01   0101. 00   10100   HOME HEALTH AGENCY   99. 00   0101. 00   10100   HOME HEALTH AGENCY   99. 00   0201. 00   Subtotal (see instructions)   16. 00   0201. 00   Less Observation Beds   200. 00   0201. 00   Subtotal (see instructions)   16. 00   0201. 00   Subtotal (see instructions)   10. 00   0201. 00   Subtotal (see instructions)   201. 00   0201. 00   Subtotal (see inst	43.00 0430	00 NURSERY					43.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0.233463   54. 00   60. 00   6000   LABORATORY   0.204639   60. 00   60500   RESPI RATORY THERAPY   0.281040   65. 00   66	ANCI	LLARY SERVICE COST CENTERS					
60. 00 06000 LABORATORY 0. 204639 60. 00 6500 RESPIRATORY THERAPY 0. 281040 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 783252 66. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 01 06901 CARDI ACR EHAB 1. 011597 69. 01 71. 00 77100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 485474 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 635069 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 380698 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 380698 73. 00 09100 EMERGENCY 0. 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 380957 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 380957 93. 01 04950 BIC 0. 000000 93. 01 04950 BIC 0. 000000 93. 01 04950 BIC 0. 000000 93. 01 04950 DI ATRY 0. 000000 93. 01 04950 DI ATRY 0. 000000 95. 00 0101. 001 1000 HOME HEALTH AGENCY 95. 00 0500 AMBULANCE SERVI CES 0. 000000 1000 OD 01000 HEALTH AGENCY 95. 00 0500 AMBULANCE SERVI CES 0. 000000 110. 001 1000 HOME HEALTH AGENCY 101. 00 SPECIAL PURPOSE COST CENTERS 116. 00 11600 HOSPI CE 0. 000000 11600 HOSPI CE 0. 000000 020. 00 Subtotal (see instructions) 200. 00 020. 00 Subtotal (see instructions) 200. 00 020. 00 Subtotal (see instructions) 200. 00 020. 00 020. 00 Subtotal (see instructions) 200. 00 020. 00 020. 00 Subtotal (see instructions) 200. 00 020.	50.00 0500	OO OPERATING ROOM	0. 474627				50.00
65. 00	54.00 0540	00 RADI OLOGY-DI AGNOSTI C	0. 233463				54.00
66. 00 06600 PHYSI CAL THERAPY 0. 783252 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 69. 01 06901 CARDI AC REHAB 1. 011597 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 485474 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 635069 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 380698 73. 00 00TPATIENT SERVICE COST CENTERS  91. 00 09100 EMERGENCY 0. 216341 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 380957 92. 00 93. 00 04050 CLI NI C 0. 456917 93. 00 93. 01 04950 BI C 0. 000000 93. 01 93. 05 04954 PODI ATRY 0. 000000 93. 01 95. 00 09500 AMBULANCE SERVICES 0. 000000 95. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 10100 HOME HEALTH AGENCY 101. 00 20. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observati on Beds 1. 011597	60.00 0600	OO LABORATORY	0. 204639				60.00
69. 00	65. 00 0650	OO RESPI RATORY THERAPY	0. 281040				65.00
69. 01   06901   CARDI AC REHAB   1. 011597   69. 01     71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 485474   71. 00     72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 635069   72. 00     73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 380698   73. 00     0017PATIENT SERVICE COST CENTERS	66. 00 0660	OO PHYSI CAL THERAPY	0. 783252				66.00
71. 00	69.00 0690	OO ELECTROCARDI OLOGY	0. 000000				69.00
72. 00	69. 01 0690	01 CARDI AC REHAB	1. 011597				69. 01
73. 00   07300   DRUGS CHARGED TO PATIENTS   0.380698   73.00	71.00 0710	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 485474				71.00
OUTPATIENT SERVICE COST CENTERS   O. 216341   91. 00     92. 00   O9200   OBSERVATION BEDS (NON-DISTINCT PART)   O. 380957   92. 00     93. 00   O4050   CLINIC   O. 456917   93. 00     93. 01   O4950   BIC   O. 000000   93. 00     93. 05   O4954   PODIATRY   O. 000000   93. 05     OTHER REIMBURSABLE COST CENTERS   O. 000000   95. 00     101. 00   TOTION HOME HEALTH AGENCY   DITION HOSPICE   O. 000000   101. 00     SPECIAL PURPOSE COST CENTERS   O. 000000   16. 00     200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00     201. 00   Less Observation Beds   O. 216341   91. 00     91. 00   O. 216341   91. 00   0. 380957   92. 00     92. 00   O. 216341   91. 00   0. 000000   93. 00     93. 05   O. 000000   O. 000000   0. 000000     95. 00   O. 000000   O. 0000000   O. 0000000     101. 00   O. 00000000   O. 0000000     102. 0000000000000000000000000000000000	72.00 0720	OO IMPL. DEV. CHARGED TO PATIENTS	0. 635069				72.00
91. 00   09100   EMERGENCY   0. 216341   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0. 380957   92. 00   93. 00   04050   CLINIC   0. 456917   93. 00   93. 01   04950   BIC   0. 000000   93. 01   04954   PODIATRY   0. 000000   93. 05   OTHER REIMBURSABLE COST CENTERS   0. 000000   95. 00   04050   AMBULANCE SERVICES   0. 000000   95. 00   05. 00	73.00 0730	DO DRUGS CHARGED TO PATIENTS	0. 380698				73.00
92. 00   09200   08SERVATION BEDS (NON-DISTINCT PART)   0. 380957   93. 00   04050   CLINIC   0. 456917   93. 00   04950   BIC   0. 000000   93. 01   04954   PODIATRY   0. 000000   93. 05   OTHER REIMBURSABLE COST CENTERS   0. 000000   95. 00   OTHER REIMBURSABLE COST CENTERS   0. 000000   95. 00   OTHER REIMBURSABLE COST CENTERS   0. 000000   95. 00   OTHER REIMBURSABLE COST CENTERS   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	OUTP	PATIENT SERVICE COST CENTERS					
93. 00	91.00 0910	OO EMERGENCY	0. 216341				91.00
93. 01	92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	0. 380957				92.00
93. 05   04954   PODI ATRY   0. 000000   93. 05	93.00 0405	50 CLINIC	0. 456917				93.00
OTHER REI MBURSABLE COST CENTERS   95.00   09500   AMBULANCE SERVI CES   0.000000   95.00   101.00   10100   HOME HEALTH AGENCY   101.00   SPECI AL PURPOSE COST CENTERS   116.00   11600   HOSPI CE   116.00   200.00   Subtotal (see instructions)   200.00   Less Observation Beds   201.00	93. 01 0495	50 BI C	0. 000000				93. 01
95. 00   09500   AMBULANCE SERVI CES   0. 0000000   101. 00   10100   HOME   HEALTH   AGENCY   101. 00   SPECI   AL   PURPOSE   COST   CENTERS   116. 00   200. 00   Subtotal   (see i instructions)   200. 00   201. 00   Less   0bservation   Beds   201. 00	93. 05 0495	54 PODI ATRY	0. 000000				93.05
101. 00	OTHE	R REIMBURSABLE COST CENTERS	<u>'</u>				1
101. 00	95.00 0950	OO AMBULANCE SERVICES	0. 000000				95.00
SPECIAL PURPOSE COST CENTERS   116.00   11600   HOSPI CE   116.00   200.00   Subtotal (see instructions)   200.00   201.00   Less Observation Beds   201.00							
116. 00       116.00       HOSPI CE       116.00         200. 00       Subtotal (see instructions)       200.00         201. 00       Less Observation Beds       201.00			<u>'</u>				
200. 00       Subtotal (see instructions)       200. 00         201. 00       Less Observation Beds       201. 00							116.00
201. 00 Less Observation Beds 201. 00							
		,					

Heal th	Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
	ATION OF RATIO OF COSTS TO CHARGES		Provi der CO		Period: From 10/01/2018 To 07/15/2019		
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 694, 831		3, 694, 83	1 0	3, 694, 831	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 521, 451		1, 521, 45	1 0	1, 521, 451	31.00
40.00	04000 SUBPROVI DER - I PF	0			0 0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	0			0 0	0	41.00
42.00	04200 SUBPROVI DER	0			0 0	0	42.00
43.00	04300 NURSERY	140, 796		140, 79	6 0	140, 796	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	O5000  OPERATI NG ROOM	1, 225, 538		1, 225, 53	8 0	1, 225, 538	50.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	2, 851, 317		2, 851, 31	7 0	2, 851, 317	54.00
60.00	06000 LABORATORY	1, 936, 448		1, 936, 44	8 0	1, 936, 448	60.00
65.00	06500 RESPI RATORY THERAPY	646, 809	0	646, 80	9 0	646, 809	65.00
	06600 PHYSI CAL THERAPY	637, 225	0	637, 22	5 0	637, 225	
(0.00	O COOO EL FOTDOOADDI OL OOV	_	1		ام ما	_	1 (0 00

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06900 ELECTROCARDI OLOGY

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

SPECIAL PURPOSE COST CENTERS

06901 CARDI AC REHAB

09100 EMERGENCY

04050 CLI NI C

04954 PODI ATRY

95. 00 09500 AMBULANCE SERVICES 101. 00 10100 HOME HEALTH AGENCY

04950 BI C

116. 00 11600 HOSPI CE

From 10/01/2018 Part I 07/15/2019 Date/Time Prepared: 12/18/2019 2:44 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 210, 639 5, 210, 639 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 537, 181 1, 537, 181 31.00 04000 SUBPROVI DER - I PF 40.00 40.00 0 41.00 04100 SUBPROVI DER - I RF 0 0 41.00 04200 SUBPROVI DER 0 42.00 42.00 0 43.00 04300 NURSERY 27, 583 27, 583 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 131, 995 2, 582, 107 0. 474627 0.000000 50.00 2, 450, 112 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 626, 898 11, 586, 254 12, 213, 152 0. 233463 0.000000 54 00 60.00 06000 LABORATORY 1, 158, 204 8, 304, 525 9, 462, 729 0. 204639 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 395, 162 1, 906, 325 2, 301, 487 0. 281040 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 13, 129 0.000000 800, 434 813, 563 0.783252 66.00 69.00 06900 ELECTROCARDI OLOGY 0 0.000000 0.000000 69.00 06901 CARDI AC REHAB 331, 372 331, 372 69.01 0 1.011597 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 311, 881 0. 485474 0.000000 71.00 305, 062 616, 943 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 910 503, 487 504.397 0.635069 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 3, 253, 474 4, 737, 542 0.380698 0.000000 73.00 73.00 1, 484, 068 OUTPATIENT SERVICE COST CENTERS 91.00 804, 181 10, 074, 758 0.000000 09100 EMERGENCY 9, 270, 577 0.216341 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 806, 408 1, 806, 408 0.380957 0.000000 92.00 1, 414 93.00 04050 CLI NI C 6, 929, 232 6, 930, 646 0.456135 0.000000 93.00 04950 BI C 93.01 0.000000 0.000000 93.01 0 0 04954 PODI ATRY 0 93.05 0 0 0.000000 0.000000 93.05 OTHER REIMBURSABLE COST CENTERS

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47, 447, 262

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201 00

202.00

95. 00 09500 AMBULANCE SERVICES

101.00 10100 HOME HEALTH AGENCY

116. 00 11600 HOSPI CE

200.00

201 00

202.00

SPECIAL PURPOSE COST CENTERS

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

Health Financial Systems	FAYETTE REGIONAL I	HEALTH SYSTEM	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019	Worksheet C Part I Date/Time Pre 12/18/2019 2:	pared: 44 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
20 00 02000 ADULTS & DEDLATRICS					20 00

			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVI DER - I PF				40.00
41.00	04100 SUBPROVI DER - I RF				41.00
42.00	04200 SUBPROVI DER				42.00
43.00	04300 NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 000000			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60.00	06000 LABORATORY	0. 000000			60.00
65.00	06500 RESPIRATORY THERAPY	0. 000000			65.00
	06600 PHYSI CAL THERAPY	0. 000000			66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69.00
69. 01	06901 CARDI AC REHAB	0. 000000			69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
	04050 CLI NI C	0. 000000			93.00
	04950 BI C	0. 000000			93. 01
93.05	04954 PODI ATRY	0. 000000			93. 05
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0. 000000			95.00
101.00	10100 HOME HEALTH AGENCY				101. 00
	SPECIAL PURPOSE COST CENTERS				
	11600 H0SPI CE				116. 00
200.00					200.00
201.00	1 1				201. 00
202.00	Total (see instructions)				202.00

Health Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM	1	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS			Period: From 10/01/2018 To 07/15/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II,	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 -	Total Patient Days	Per Diem (col. 3 / col. 4)	
	col. 26)		col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	104, 773	0	104, 77		24. 92	
31.00   INTENSIVE CARE UNIT	63, 072		63, 07	2 144	438. 00	
40. 00 SUBPROVI DER - I PF	0	0	1	0 0	0. 00	
41. 00 SUBPROVI DER - I RF	0	0		0 0	0. 00	
42. 00 SUBPROVI DER	0	0	1	0 0	0. 00	
43. 00 NURSERY	29, 685		29, 68		1, 290. 65	
200.00 Total (lines 30 through 199)	197, 530		197, 53	0 4, 371		200.00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
	6. 00	col. 6) 7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	568	14, 155				30.00
31. 00   INTENSIVE CARE UNIT	71	31, 098				31.00
40. 00 SUBPROVI DER - I PF	0	0.,0,0				40.00
41. 00 SUBPROVIDER - IRF	0	0	,			41.00
42. 00 SUBPROVI DER	0	0	,			42.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	639	45, 253				200. 00

	AYETTE REGIONAL				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 10/01/2018 To 07/15/2019		narod:
				10 07/13/2019	12/18/2019 2:	44 pm
Title XVIII Hospital PP						
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			,	_		
50. 00   05000 OPERATING ROOM	136, 781		0. 05297	· ·		
54. 00   05400   RADI OLOGY-DI AGNOSTI C	109, 396		0. 00895			54.00
60. 00   06000   LABORATORY	55, 949		0. 00591			
65. 00  06500 RESPIRATORY THERAPY	26, 126	2, 301, 487			2, 849	65.00
66. 00  06600 PHYSI CAL THERAPY	43, 607	813, 563			573	66.00
69. 00  06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69. 00
69. 01  06901   CARDI AC REHAB	20, 201		0. 06096		0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 144	616, 943	0. 02941	0 219, 936	6, 468	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 121	504, 397	0. 00222			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	24, 031	4, 737, 542	0. 00507	2 400, 982	2, 034	73.00
OUTPATIENT SERVICE COST CENTERS						
91. 00   09100   EMERGENCY	67, 033	10, 074, 758	0. 00665	4 671, 613	4, 469	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	19, 514	1, 806, 408	0. 01080	3 0	0	92.00
93. 00  04050   CLI NI C	177, 655	6, 930, 646	0. 02563	3 393	10	93.00
93. 01  04950 BI C	0	0	0.00000	0 0	0	93. 01
93. 05 04954 PODI ATRY	0	0	0.00000	0 0	0	93.05
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50 through 199)	699, 558	52, 375, 104		2, 779, 690	27, 311	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 10/01/2018 To 07/15/2019	Date/Time Pre 12/18/2019 2:	epared: 44 pm
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School Post-Stepdown Adj ustments	Nursi ng School	Allied Health Post-Stepdowr Adjustments	Allied Health Cost	All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSI VE CARE UNI T 40. 00   04000   SUBPROVI DER - I PF 41. 00   04100   SUBPROVI DER - I RF 42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	000000000000000000000000000000000000000		l .	0 0 0 0 0 0 0 0	0 0 0 0 0	31.00 40.00 41.00 42.00
200.00 Total (lines 30 through 199)	Ö	l o		o o		200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4) 5.00	Total Patient Days 6.00	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days 8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
30. 00	0 0 0	0	14	4 0. 00 0 0. 00 0 0. 00 0 0. 00 0 0. 00 3 0. 00	568 71 0 0 0 0 0	31.00 40.00 41.00 42.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	0 0 0 0 0					30.00 31.00 40.00 41.00 42.00 43.00 200.00

Health Financial Systems	FAYETTE REGIONAL	HEALTH SYSTEM	In Lie	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		S Provider CCN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019	Worksheet D Part IV Date/Time Prepared: 12/18/2019 2:44 pm		
		Title XVIII	Hospi tal	PPS		
Cost Center Description	Non Physician	Nursing Nursing	Allied Health	Allied Health		

						12/18/2019 2:	44 pm
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	C	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
	06000 LABORATORY	0	0	C	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66.00
	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
	06901 CARDI AC REHAB	0	0	C	0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	) C	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	0	C	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		C		0	92.00
93.00	04050 CLI NI C	0	0	C	0	0	93.00
93. 01	04950 BI C	0	0	C	0	0	93. 01
93.05	04954 PODI ATRY	0	0	C	0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	0	0	d c	0	0	200.00

Heal th	Financial Systems F	AYETTE REGIONAL	. HEALTH SYSTEM	I	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS		RVICE OTHER PAS	S Provider C	CN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019		pared: 44 pm
Title XVIII Hospital PPS					PPS		
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and			(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS		T	,			
50.00	05000 OPERATING ROOM	0	0	1	0 2, 582, 107		1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 213, 152		
60.00	06000 LABORATORY	0	0		0 9, 462, 729		
65. 00	06500 RESPI RATORY THERAPY	0	0		0 2, 301, 487		
66.00	06600 PHYSI CAL THERAPY	0	0		0 813, 563		
69. 00	06900 ELECTROCARDI OLOGY	0	0	)	0	0.000000	
69. 01	06901 CARDI AC REHAB	0	0	1	0 331, 372		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0 616, 943	0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0 504, 397	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 4, 737, 542	0. 000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0		0 10, 074, 758	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	)	0 1, 806, 408	0.000000	92.00
93.00	04050 CLI NI C	0	0	)	0 6, 930, 646	0.000000	93.00
93. 01	04950 BI C	0	0	)	0 0	0.000000	93. 01
93. 05	04954 PODI ATRY	0	0		0 0	0.000000	93. 05

0

0

95. 00 200. 00

52, 375, 104

0

OTHER REI MBURSABLE COST CENTERS
95.00 O9500 AMBULANCE SERVICES
200.00 Total (lines 50 through 199)

Heal th	ealth Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lieu of Form CMS-2552-10							
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS				Period: From 10/01/2018 To 07/15/2019	Date/Time Pre 12/18/2019 2:	pared: 44 pm	
			Title	XVIII	Hospi tal	PPS		
	Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program		
		to Charges (col. 6 ÷	Charges	Pass-Through Costs (col.		Pass-Through Costs (col. 9		
		col. 7)		x col. 10)		x col. 12)		
		9. 00	10. 00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0. 000000	39, 814		0 891, 548	0	50.00	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	589, 422		0 3, 824, 942	0	54.00	
60.00	06000 LABORATORY	0. 000000	594, 947		0 1, 648, 164	0	60.00	
65.00	06500 RESPI RATORY THERAPY	0. 000000	250, 974		0 834, 517	0	65.00	
66.00	06600 PHYSI CAL THERAPY	0. 000000	10, 699		0 2, 308	0	66. 00	
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00	
69. 01	06901 CARDI AC REHAB	0. 000000	0		0 201, 685		69. 01	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	219, 936		0 254, 849	0	,	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	910		0 11, 324		72. 00	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	400, 982		0 1, 400, 179	0	73. 00	
	OUTPATIENT SERVICE COST CENTERS							
91. 00	09100 EMERGENCY	0. 000000	671, 613		0 2, 236, 602			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 277, 067		92.00	
93.00	04050 CLI NI C	0. 000000	393		0 1, 010, 243	0		
93. 01	04950 BI C	0. 000000	0		0	0		
93. 05	04954 PODI ATRY	0. 000000	0		0 0	0	93. 05	
	OTHER REIMBURSABLE COST CENTERS							
	09500 AMBULANCE SERVICES						95.00	
200.00	Total (lines 50 through 199)	1	2, 779, 690		0 12, 593, 428	0	200. 00	

Health Financial Systems	FAYETTE REGIONAL HE	In Lieu of Form CMS-2552-1		
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019	Worksheet D Part V Date/Time Prepared: 12/18/2019 2:44 pm

					o 07/15/2019	Date/Time Pre 12/18/2019 2:	
			Title	xVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	0. 474627	891, 548	l .	0	423, 153	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 233463		1	0	892, 982	1
60.00	06000 LABORATORY	0. 204639	,	1	0	337, 279	
65.00	06500 RESPI RATORY THERAPY	0. 281040		1	0	234, 533	1
66.00	06600 PHYSI CAL THERAPY	0. 783252		(	0	1, 808	1
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	l e	(	0	0	69. 00
69. 01	06901 CARDI AC REHAB	1. 011597	201, 685	1	0	204, 024	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 485474		1	0	123, 723	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 635069		(	0	7, 192	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 380698	1, 400, 179	(	50, 960	533, 045	73. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 216341	2, 236, 602		0	483, 869	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 380957		1	0	105, 551	92.00
	04050 CLI NI C	0. 456135		C	360	460, 807	93.00
	04950 BI C	0. 000000	l e	(	0	0	
93. 05	04954 PODI ATRY	0. 000000	0	(	0	0	93. 05
	OTHER REIMBURSABLE COST CENTERS	_					
	09500 AMBULANCE SERVI CES	0. 000000	l e	0	)		95.00
200.00	,		12, 593, 428	(	51, 320		1
201.00					0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		12, 593, 428	(	51, 320	3, 807, 966	202.00

Н	ealth Financial Systems F <i>n</i>	AYETTE REGIONAL	_ HEALTH SYSTEM	l	In Lie	ı of Form CMS-	2552-10
	PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provi der C	CN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019	Worksheet D Part V	pared:
			Title	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description  ANCILLARY SERVICE COST CENTERS	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
5	0.00 05000 OPERATING ROOM						50.00
	4. 00   05400  RADI OLOGY-DI AGNOSTI C						54.00
	0. 00   06000   LABORATORY						60.00
	5. 00 06500 RESPIRATORY THERAPY		0				65.00
	6. 00 06600 PHYSI CAL THERAPY	0	Ō				66.00
6	9. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
6	9. 01   06901   CARDI AC   REHAB	0	0				69. 01
_		1	1	1			1

Heal th Financial	Systems		FAYETTE REGIONAL	_ HEALTH SYSTEM	1	In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF	MEDICAL, OTHER	R HEALTH SERVICES /	AND VACCINE COST	Provider C	1	Period: From 10/01/2018 To 07/15/2019	Worksheet D Part V Date/Time Pre	pared:
				'		wing Beds - SNF	12/18/2019 2:	
					Charges		Costs	
Cost	Center Descri	oti on	Cost to	PPS	Cost	Cost	PPS Services	
			Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
			From	Services (see	Servi ces	Services Not		
			Worksheet C,	inst.)	Subject To	Subject To		
			Part I, col.		Ded. & Coins.	Ded. & Coins.		
			9		(see inst.)	(see inst.)		
			1. 00	2.00	3, 00	4.00	5. 00	

				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 474627	0	0	0	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 233463	0	0	0	0	54.00
60.00	06000 LABORATORY	0. 204639		0	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 281040	0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 783252	0	0	0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0	0	0	0	69.00
69. 01	06901 CARDI AC REHAB	1. 011597	0	0	0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 485474	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 635069	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 380698	0	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0. 216341	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 380957	0	0	0	0	92.00
93.00	04050 CLI NI C	0. 456135	0	0	0	0	93.00
93. 01	04950 BI C	0. 000000	0	0	0	0	93. 01
93.05	04954 PODI ATRY	0. 000000	0	0	0	0	93.05
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0. 000000		0			95.00
200.00	Subtotal (see instructions)		0	0	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program			0	0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	0	0	0	202.00

	· · · · · · · · · · · · · · · · · · ·	AYETTE REGIONAL			-	<u>lieu of Form CMS</u>	-2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0064	Peri od:	Worksheet D	
			Component	CCN: 15-U064	From 10/01/20 To 07/15/20		onarod:
			Component	CCN. 15-0004	10 0//13/20	12/18/2019 2	
			Ti tl e	: XVIII	Swing Beds -		p
		Cos	sts				
	Cost Center Description	Cost	Cost	1			
	•	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7.00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C				50.00
54.00	05400   RADI OLOGY-DI AGNOSTI C	0	C				54.00
60.00	06000 LABORATORY	0	C				60.00
65.00	06500 RESPI RATORY THERAPY	0	C				65.00
66.00	06600 PHYSI CAL THERAPY	0	C				66.00
69.00	06900 ELECTROCARDI OLOGY	0	C				69.00
69. 01	06901 CARDI AC REHAB	0	C				69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C				73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	C				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	)			92.00
93.00	04050 CLI NI C	0	C	)			93.00
93. 01	04950 BI C	0	C	)			93. 01
93. 05	04954 PODI ATRY	0	C	)			93.05
	OTHER RELIMBURGARIE COST CENTERS						

0 0 0

0

95. 00 200. 00

201.00 202.00

93.05 O4954|PODIATRY
OTHER REIMBURSABLE COST CENTERS

95.00 O9500| AMBULANCE SERVICES

200.00 | Subtotal (see instructions)

201.00 | Less PBP Clinic Lab. Services-Program
Only Charges

202.00 | Net Charges (line 200 - line 201)

Heal th	Financial Systems	FAYETTE REGIONAL H	FALTH SYSTEM	In lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	TATELLE REGIONAL II	Provi der CCN: 15-0064	Peri od:	Worksheet D-1	
				From 10/01/2018 To 07/15/2019	Date/Time Pre	pared:
			Title XVIII	11	12/18/2019 2:	44 pm
	Cost Center Description		II tie xviii	Hospi tal	PPS	
	cost center bescription				1. 00	
	PART I - ALL PROVIDER COMPONENTS				1.00	
1. 00	INPATIENT DAYS Inpatient days (including private room	days and swing had day	vs ovel uding newborn)	1	4, 204	1.00
2. 00	Inpatient days (including private room				4, 204	1
3. 00	Private room days (excluding swing-bed			rivate room days	4, 204	1
3.00	do not complete this line.	and observation bed de	ays). If you have only p	Trvate room days,		3.00
4.00	Semi-private room days (excluding swin	g-bed and observation I	ped days)		3, 421	4.00
5. 00	Total swing-bed SNF type inpatient day			er 31 of the cost	0, .2.	1
	reporting period	- (	,g			
6. 00	Total swing-bed SNF type inpatient day	s (including private r	oom davs) after December	31 of the cost	0	6.00
	reporting period (if calendar year, en				- 1	
7.00	Total swing-bed NF type inpatient days		om days) through Decembe	r 31 of the cost	0	7.00
	reporting period	. 31	3 , 3		i	
8.00	Total swing-bed NF type inpatient days	(including private roo	om days) after December :	31 of the cost	0	8.00
	reporting period (if calendar year, en	ter 0 on this line)			i	
9.00	Total inpatient days including private	room days applicable	to the Program (excluding	g swing-bed and	568	9.00
	newborn days)				i	
10.00	Swing-bed SNF type inpatient days appl			room days)	0	10.00
	through December 31 of the cost report				i	
11. 00	Swing-bed SNF type inpatient days appl			room days) after	0	11.00
	December 31 of the cost reporting peri				i	
12. 00	Swing-bed NF type inpatient days appli		IX only (including priva	te room days)	0	12.00
40.00	through December 31 of the cost report					40.00
13. 00	Swing-bed NF type inpatient days appli				0	13.00
14 00	after December 31 of the cost reportin				0	14 00
14. 00 15. 00	Medically necessary private room days		rail (excluding swing-bed	uays)	0	
16. 00	Total nursery days (title V or XIX only)	у)			0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				0	16.00
17. 00	Medicare rate for swing-bed SNF servic	os applicable to servi	cos through Docombor 21	of the cost	0.00	17. 00
17.00	reporting period	es applicable to servi	ces till odgir becelliber 31 t	Ji the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF servic	es annlicable to servi	res after December 31 of	the cost	0. 00	18. 00
10.00	reporting period	es appricable to servi	des arter becomber or or	110 0031	0.00	10.00
19. 00	Medicaid rate for swing-bed NF service	s applicable to service	es through December 31 o	f the cost	0.00	19.00
	reporting period					
20.00	Medicaid rate for swing-bed NF service	s applicable to service	es after December 31 of	the cost	0.00	20.00
	reporting period				i	
21.00	Total general inpatient routine servic	e cost (see instruction	ns)		3, 694, 831	21.00
22. 00	Swing-bed cost applicable to SNF type	services through Deceml	per 31 of the cost repor	ting period (line	0	22. 00
	5 x line 17)				ı	
23.00	Swing-bed cost applicable to SNF type	services after Decembe	r 31 of the cost reporti	ng period (line 🏻	0	23. 00
	x line 18)				i	
24. 00	Swing-bed cost applicable to NF type s	ervices through Decembe	er 31 of the cost report	ing period (line	0	24.00
05.00	7 x line 19)					05.00
25. 00	Swing-bed cost applicable to NF type s	ervices after December	31 of the cost reporting	g period (line 8	0	25. 00
24 00	x line 20)	`			_	24 00
26. 00	Total swing-bed cost (see instructions	•	(line 21 misses line 20)		2 404 931	1
27. 00	General inpatient routine service cost	net of Swing-bed Cost	(TIME 21 IIII NUS TIME 26)		3, 694, 831	27.00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service char	as (evaluding swing b	and observation had a	narnes)	0	28. 00
28. 00 29. 00	Private room charges (excluding swing-		ed and observation bed C	iai yes)	0	
20.00	Comi privata room charges (excluding swilly-	wing had charges)			0	27.00

	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	11.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 204	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 204	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4 00	do not complete this line.	2 421	4 00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3, 421	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	Ü	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	568	9. 00
40.00	newborn days)		10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Ŭ,	12.00
13.00		0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10 00	reporting period  Medicaid rate for swips had NE carvices applicable to sarvices through December 21 of the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00		0. 00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	3, 694, 831	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
	x line 18)		
24.00		0	24.00
	7 x line 19)	_	
25. 00		0	25. 00
24 00	x line 20)	0	24 00
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	0 3, 694, 831	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	3, 094, 031	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Pri vate room charges (excluding swing-bed charges)	0	29. 00
	Semi -pri vate room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 000000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34. 00		0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	878. 88	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	499, 204	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	499, 204	41.00

Title   VIII   Hospital   Program Days   Program	2: 44 pm 0 42.00
Cost Center Description	0 42.00 0 43.00 44.00 45.00 46.00
Inpatient   Inpatient   Diem (Col. 1   Col. 3 x   Col. 4   Col. 4   Col. 5   Days   + col. 2   + col. 2   Col. 4   Col. 4   42.00   NURSERY (fittle V & XIX only)   1.00   2.00   3.00   4.00   5.00	0 42.00 0 43.00 44.00 45.00 46.00
Cost	43. 00 44. 00 45. 00 46. 00
1.00   2.00   3.00   4.00   5.00   0   0.00   0   0   0   0   0   0	43. 00 44. 00 45. 00 46. 00
All Companies   All Companie	43. 00 44. 00 45. 00 46. 00
Intensive Care Type Inpatient Hospital Units 43.00   INFINITY CARE UNIT   1,521,451   144   10,565,63   71   750,1   44.00   CORONARY CARE UNIT   1,521,451   144   10,565,63   71   750,1   45.00   BURN INTENSIVE CARE UNIT   1,521,451   144   10,565,63   71   750,1   46.00   SURGICAL INTENSIVE CARE UNIT   1,521,451   144   10,565,63   71   750,1   47.00   OTHER SPECIAL CARE (SPECIFY)   1,000   1,000   48.00   Program inpatient costs (sum of lines 41 through 48) (see instructions)   762,6   48.00   Program inpatient costs (sum of lines 41 through 48) (see instructions)   2,012,0   48.00   PASS THROUGH COST ADJUSTMENTS   2,012,0   48.00   Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)   1,000   45.00   Total Program excludable cost (sum of lines 50 and 51)   72,5   45.00   Total Program excludable cost (sum of lines 50 and 51)   72,5   45.00   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)   7,939,4   45.00   Program discharges   0,144   1,000   1,000   46.00   Target amount (line 54 x line 55)   7,000	43. 00 44. 00 45. 00 46. 00
43.00   INTERSIVE CARE UNIT   1.521,451   144   10,565.63   71   750.1   46.00   SURGIAL INTERSIVE CARE UNIT   1.521,451   144   10,565.63   71   750.1   47.00   OTHER SPECIAL CARE (SPECIFY)   1.00	44. 00 45. 00 46. 00
44.00 CORRONARY CARE UNIT 45.00 BURGICAL INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  Cost Center Description  1.00  762.6 49.00 Total Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)  762.6 49.00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions)  763.5 THROUGH COST ADJUSTMENTS  763.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts II and II)  764.01 Total Program excludable cost (sum of lines 50 and 51)  765.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and inedical education costs (line 49 minus line 52)  765.00 Total Program discharges  765.00 Target amount per discharge  765.00 Target amount per discharge  766.00 Target amount per discharge  767.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  768.00 Bonus payment (see instructions)  769.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  769.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  769.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  769.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  769.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  769.00 Lesser of lines 53/54 or 55 from prior year cost report ing period ending 1996, updated and compounded by the market basket  769.00 Lesser of lines 53/54 or 55 from prior year cost report ing period ending 1996, updated and compounded by the market basket  769.00 Lesser of lines 53/54 or 55 from prior year cost report ing period ending 1996, updated and compounded by the market basket  760.00 Lesser of lines 53/54 or 55 from prior year cost report ing period ending 1996, updated and compounded by the market basket	44. 00 45. 00 46. 00
45.00   BURN INTENSIVE CARE UNIT   47.00   OTHER SPECIAL CARE (SPECIFY)	45. 00 46. 00
46.00 SURGICAL INTENSIVE CARE UNIT  7.00 OTHER SPECIAL CARE (SPECIFY)  Cost Center Description  1.00  48.00 Program inpatient ancillary service cost (Wsst. D-3, col. 3, line 200)  PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and II)  1.11  50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and II)  51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts I I and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and part and III and	46. 00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 762, 6 49.00 Total Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 762, 6 49.00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 2, 012, 0 48.50 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minu line 52) 53.00 Total Program discharges 54.00 Program discharges 55.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bous payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Relief payment (see instructions) 60.00 Relief payment (se	
Cost Center Description 1.00  48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 7.62, 6  49.00 Total Program inpatient costs (sum of lines 41 through 48) (see instructions) 2, 012, 0  PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and II)  51.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts II and IIV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges  55.00 Target amount per discharge  60.01 Target amount per discharge  60.02 Target amount per discharge  60.03 Bonus payment (see instructions)  61.00 If line 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  61.00 Iii line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Rellef payment (see Instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions) (file 50), otherwise enter zero (see instructions)  64.00 Microam Simpatient Cost plus line for patient routine costs after December 31 of the cost reporting period (See instructions) (file Vor XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  65.00 Total Ittle Vor XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  66.00 Total Mcdicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  67.00	
18.00   Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)   762.6	
49.00 Total Program Inpatient costs (sum of lines 41 through 48)(see instructions)  Pass THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)  51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  TARGET ANOUNT AND LIMIT COMPUTATION  54.00 Program discharges  55.00 Target amount per discharge  56.00 Target amount (line 54 x line 55)  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58.00 Bonus payment (see instructions)  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  60.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title VVIII volly)  66.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  67.00 Title Vor XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	
PASS THROUGH COST ADJUSTMENTS  50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)  51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts III 27, 3 and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 1, 939, 4 medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges  55.00 Target amount (line 54 x line 55)  57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  58.00 Bosus payment (see instructions)  59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  61.00 Lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  67.00 Title Vor XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	9 48.00
Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	3 49.00
111   Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)   27, 3 and IV)   72, 5   70   70   70   70   70   70   70	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)  52.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program excludable cost (sum of lines 50 and 51)  53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 40 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  56.00 Torgoram discharges  57.00 Total Program discharge  58.00 Target amount per discharge  58.00 Target amount (line 54 x line 55)  58.00 Bonus payment (see instructions)  58.00 Bonus payment (see instructions)  58.00 Bonus payment (see instructions)  58.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  69.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  69.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  69.00 Relief payment (see instructions)  69.00 Relief payment (see instructions)  69.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  69.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  69.00 Total Medicare swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	50.00
Total Program excludable cost (sum of lines 50 and 51)   Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)   TARGET AMOUNT AND LIMIT COMPUTATION	
52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)  TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges 55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions) 67.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line	1 51.00
Target amount (line 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating cost plus incentive payment (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 10 title XVIII only)  65.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  66.00 Total Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  67.00 Total Itile V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  68.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  60.00 Total title V or XIX swing-bed NF inpatient routine costs (line (line 70 + line 2))	A E2 00
medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION  54.00 Program discharges 55.00 Target amount per discharge 66.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWIN GB ED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)	
TARGET AMOUNT AND LIMIT COMPUTATION  Program discharges  55.00  Target amount per discharge  55.00  Target amount (line 54 x line 55)  Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)  80.00  Bonus payment (see instructions)  Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket  60.00  Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  61.00  If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00  Relief payment (see instructions)  63.00  Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (it ite XVIII only)  65.00  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (it ite XVIII only)  67.00  Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00  Adjusted general inpatient routine costs per diem (line 70 + line 2)	9 53.00
54.00 Program discharges 55.00 Target amount per discharge 56.00 Target amount per discharge 56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine costs per diem (line 70 + line 2)	_
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market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket  61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  62.00 Relief payment (see instructions)  63.00 Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)	0 58.00
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61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions)  Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2)	
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amount (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions)  Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  70.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  71.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  72.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  73.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  74.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0 61.00
Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	
Allowable Inpatient cost plus incentive payment (see instructions)  PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  70.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  71.00 Adjusted general inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0 62.00
PROGRAM INPATIENT ROUTINE SWING BED COST  64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)  65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)  70.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)  71.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  70.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0 63.00
<ul> <li>Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)</li> <li>Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)</li> <li>Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)</li> <li>Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)</li> <li>Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)</li> <li>Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)</li> <li>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY</li> <li>Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)</li> <li>Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)</li> </ul>	03.00
instructions)(title XVIII only)  Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)  71.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  72.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  73.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0 64.00
instructions)(title XVIII only)  66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)  7.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  7.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	
Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)  Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0 65.00
CAH (see instructions)  67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)  68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0 66.00
(line 12 x line 19)  7 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  7 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0 67.00
(line 13 x line 20)  69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0 68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	00.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY  70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)  71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	0 69.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	Ŧ */. 50
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	70.00
	71.00
	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column	75. 00
26, line 45)	7, 00
76.00   Per diem capital related costs (line 75 ÷ line 2)	76.00
77.00   Program capital-related costs (line 9 x line 76) 78.00   Inpatient routine service cost (line 74 minus line 77)	77. 00 78. 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	80.00
81.00 Inpatient routine service costs for comparison to the cost fram tatron (frae 70 minus frae 77)	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)	82.00
83.00 Reasonable inpatient routine service costs (see instructions)	
84.00 Program inpatient ancillary services (see instructions)	83.00
85.00 Utilization review - physician compensation (see instructions)	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)	83.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	83. 00 84. 00
, ,	83. 00 84. 00 85. 00 86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 878.	83. 00 84. 00 85. 00 86. 00
89.00   Observation bed cost (line 87 x line 88) (see instructions) 688,1	83. 00 84. 00 85. 00 86. 00 83 87. 00 88 88. 00

Health Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2018 To 07/15/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	104, 773	3, 694, 831	0. 02835	688, 163	19, 514	90.00
91.00 Nursing School cost	0	3, 694, 831	0.00000	00 688, 163	0	91.00
92.00 Allied health cost	0	3, 694, 831	0.00000	688, 163	0	92.00
93.00 All other Medical Education	0	3, 694, 831	0. 00000	688, 163	0	93.00

	Financial Systems FAYETTE REGIONAL F ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0064	Period:	u of Form CMS-2 Worksheet D-1	
001111 01	THE STERMING GOOT	11001 del 10001. 10 0001	From 10/01/2018		
			To 07/15/2019	Date/Time Pre 12/18/2019 2:	
		Title XIX	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				4
4 00	I NPATI ENT DAYS	The state of the s		4 004	1
1.00	Inpatient days (including private room days and swing-bed da			4, 204	
2.00	Inpatient days (including private room days, excluding swing			4, 204	
3. 00	Private room days (excluding swing-bed and observation bed d	ays). If you have only p	rivate room days,	0	3.00
	do not complete this line.			0.404	
4.00	Semi-private room days (excluding swing-bed and observation			3, 421	4.00
5. 00	Total swing-bed SNF type inpatient days (including private r	oom days) through Decemb	er 31 of the cost	0	5. 00
4 00	reporting period Total swing-bed SNF type inpatient days (including private r	aam daya) aftar Daaambar	21 of the cost	0	6.00
6. 00	reporting period (if calendar year, enter 0 on this line)	dolli days) arter becellber	31 OF the Cost	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private ro	om days) through Docombo	or 21 of the cost	0	7.00
7.00	reporting period	om days) thi ough becembe	i 31 of the cost	O	7.00
8. 00	Total swing-bed NF type inpatient days (including private ro	om davs) after December	31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber	or or the cost	Ü	0.00
9. 00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	497	9.00
	newborn days)	3 (	5		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days)	0	10.00
	through December 31 of the cost reporting period (see instru	ctions)	-		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year,				
12.00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	ite room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13.00
14 00	after December 31 of the cost reporting period (if calendar			0	14.00
	Medically necessary private room days applicable to the Prog	ram (excluding swing-bed	days)	_	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
16.00	SWING BED ADJUSTMENT			U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost	0.00	17. 00
17.00	reporting period	ces through becember 31	or the cost	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0. 00	18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 c	of the cost	0.00	19.00
	reporting period	3			
20.00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instruction			3, 694, 831	
22.00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	0	22.00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23. 00
04.00	x line 18)			_	04.65
24. 00	Swing-bed cost applicable to NF type services through Decemb	er 31 of the cost report	ing period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost report:	a ported (line o	0	25. 00
25.00	x line 20)	or or the cost reportin	ig periou (Title 8		25.00
	Total swing-bed cost (see instructions)				1

Impatient days (including private room days, excluding swing-bed and newborn days)   4,204   2,00		PART I - ALL PROVIDER COMPONENTS		
1. Impattent days (including private room days, excluding singl-bed and nerborn days) 2. On Private room days (excluding singl-bed and observation bed days). If you have only private room days. 3. 0				
9.00 private room days (excluding swing-bed and observation bed days). If you have only private room days. do do not complete this line.  4.00 Semi-private room days (excluding swing-bed and observation bed days).  5.00 Total swing-bed SWE type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  7.00 Total swing-bed SWE type inpatient days. (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  7.00 Total swing-bed NF type inpatient days. (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  8.00 Total swing-bed NF type inpatient days. (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  9.00 Swing-bed SWE type inpatient days applicable to the Program (excluding swing-bed and newborn days).  10.00 Swing-bed SWE type inpatient days applicable to title aVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  10.00 Swing-bed SWE type inpatient days applicable to title aVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  10.00 Swing-bed SWE type inpatient days applicable to title aVII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line).  10.00 Total problember 31 of the cost reporting period (if calendar year, enter 0 on this line).  10.00 Total problember 31 of the cost reporting period (if calendar year, enter 0 on this line).  10.00 Total problember 31 of the cost reporting period (if calendar year, enter 0 on this line).  10.00 Total problember 31 of the cost reporting period (if calendar year, enter 0 on this line).  10.00 Total problember 31 of the cost reporting period (if calendar year, enter 0 on this line).  10.			4, 204	1.00
do not complete this line.  4. 00 Sein-jn-inviter come days (exectualing swing-bed and observation bed days) through December 31 of the cost 0. 5.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 0. 5.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 0. 5.00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost 0. 7.00 reporting period (if calendar year, enter 0.00 this line)  7. 00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost 1. 7.00 reporting period (if calendar year, enter 0.00 this line)  9. 00 Total swing-bed MF type inpatient days (including private room days) after December 31 of the cost 1. 7.00 reporting period (if calendar year, enter 0.00 this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and nestore days) including private room days)  10. 00 Sing-bed SMF type inpatient days applicable to title SMI only (including private room days) after 0. 11.00 Sing-bed SMF type inpatient days applicable to title SMI only (including private room days) after 0. 11.00 Sing-bed SMF type inpatient days applicable to title SMI only (including private room days) after 0. 11.00 Sing-bed SMF type inpatient days applicable to title SMI only (including private room days) after 0. 11.00 Sing-bed NF type inpatient days applicable to title SMI only (including private room days) 0. 13.00 after December 31 of the cost reporting period (if calendar year, enter 0.00 this line)  13. 00 Sing-bed NF type inpatient days applicable to title SMI only (including private room days) 0. 13.00 after December 31 of the cost reporting period (including private room days) 0. 13.00 after December 31 of the cost reporting period (including private room days) 0. 13.00 after 0.00 after 0.	2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	4, 204	2.00
5.00 Total swing-bed SNF type inpatient days. (Including private room days) through December 31 of the cost open reporting period.  6.00 Total swing-bed NF type inpatient days. (Including private room days) after December 31 of the cost open reporting period.  7.00 Total swing-bed NF type inpatient days. (Including private room days) after December 31 of the cost reporting period.  8.00 Total swing-bed NF type inpatient days. (Including private room days) after December 31 of the cost reporting period.  8.00 Total swing-bed NF type inpatient days. (Including private room days) after December 31 of the cost reporting period.  8.00 Total swing-bed NF type inpatient days. (Including private room days) after December 31 of the cost reporting period.  8.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and days) after December 31 of the cost reporting period.  8.00 Swing-bed SNF type inpatient days applicable to the Itle SWII along (Including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line).  8.00 Swing-bed NF type inpatient days applicable to title SW or XIX only (Including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line).  8.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line).  8.00 Note the NF type inpatient days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line).  8.00 Note the NF type inpatient days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (Including the NF type inpatient days applicable to the Program (excluding swing-bed days).  8.01 Note the NF type inpatient days applicable to the Program (excluding swing-bed days).  8.02 Note the NF type inpatient private	3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
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newborn days)  newborn days)  10. OS wing-bed SNF type inpatient days applicable to title XVIII only (including private room days) of through December 31 of the cost reporting period (see instructions)  11. OS wing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. OS wing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. OS wing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of the cost reporting period (if calendar year, enter 0 on this line)  14. OS of Total nursery days (title V or XIX only) of the Program (excluding swing-bed days) 23 is 5.00  15. OS of Total nursery days (title V or XIX only) of the Program (excluding swing-bed days) 23 is 5.00  16. OS Wing-BED ADJUSTMENT  17. OS Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost on the program (excluding swing-bed swing-bed SNF services applicable to services after December 31 of the cost on the program (excluding swing-bed swing-bed SNF services applicable to services after December 31 of the cost on the program (excluding swing-bed swing-bed SNF services applicable to services after December 31 of the cost on the program (excluding swing-bed swing-bed swing-bed swing-bed SNF services applicable to services after December 31 of the cost on the cost of the cost of the cost reporting period (line swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line sw		reporting period (if calendar year, enter 0 on this line)		
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through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to titlex Vor XIX only (including private room days) after 0 11.00 December 31 of the cost reporting period (if cal endar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titlex V or XIX only (including private room days) 0 12.00 through December 31 of the cost reporting period (if cal endar year, enter 0 on this line)  14.00 Medical pracessary private room days applicable to titlex V or XIX only (including private room days) 0 13.00 after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)  14.00 Medical Iy necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 Total nursery days (title V or XIX only) 2 23 15.00 Total nursery days (title V or XIX only) 2 15.00 Notical reproved yasy (title V or XIX only) 2 16.00 Notical care rate for swing-bed SNF services applicable to services through December 31 of the cost 0.00 17.00 Noticare rate for swing-bed SNF services applicable to services after December 31 of the cost 0.00 18.00 reporting period 19.00 Noticaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Noticaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Noticaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Noticaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 19.00 Noticaid rate for swing-bed NF services after December 31 of the cost reporting period (line 0.00 Noticaid rate for swing-bed NF services after December 31 of the cost reporting period (line 0.00 Noticaid rate for swing-bed NF services after December 31 of the cost reporting period (line 0.00 Noticaid general inpatient routine service cost (see instructions) 10 Noticaid general inpatient pout notice NF type services after December 31 of the cost re		newborn days)		
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December 31 of the cost reporting period (if callendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically inecessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medical rare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including swing-bed days)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost one reporting period (including swing-bed SNF services)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost one reporting period (including swing-bed SNF services applicable to services after December 31 of the cost one reporting period (including swing-bed SNF services applicable to services after December 31 of the cost one reporting period (including swing-bed SNF services applicable to services after December 31 of the cost one reporting period (including swing-bed SNF services applicable to services after December 31 of the cost one one of swing-bed SNF services applicable to services after December 31 of the cost one one of swing-bed SNF services after December 31 of the cost one of swing-bed SNF services after December 31 of the cost reporting period (line one of swing-bed Cost applicable to SNF type services after December 31 of the cost reporting period (line one of swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line one of swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line one of swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line one of swing-bed cost (swing-bed cost (swell and		through December 31 of the cost reporting period (see instructions)		
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after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14.00   15.00   16.00   17		through December 31 of the cost reporting period		
14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00	13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
15.00   Total nursery days (title V or XIX only)   23   15.00				
16.00 Nursery days (title V or XIX only)  SIMB BED ADJUSTMENT  17.00 SWING BED ADJUSTMENT  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting r	14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
SWING BED ADJUSTMENT  17. 00  18. 00  18. 00  18. 00  19. 00  Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (19. 00)  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (19. 00)  Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost (19. 00)  December 31 of the cost (19. 00)  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (19. 00)  December 31 of the cost reporting period (19. 00)  De	15.00	Total nursery days (title V or XIX only)	23	15.00
SWING BED ADJUSTMENT  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost period reporting period (are rate for swing-bed SNF services applicable to services after December 31 of the cost period (are rate for swing-bed SNF services applicable to services after December 31 of the cost (are of a cost period (are rate for swing-bed NF services applicable to services after December 31 of the cost (are of a cost period (are of a cost	16.00	Nursery days (title V or XIX only)	0	16.00
reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 24)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 O Total routine service charges (excluding swing-bed charges)  30.00 Average perivate room charges (excluding swing-bed charges)  30.00 Average perivate room per diem charge (line 29 + line 3)  30.00 Average peridem private room charge differential (line 3 x line 31)  27.00 General inpatient routine service cost formula (line 3 x line 31)  30.00 Average per diem private room charge differential (line 3 x line 31)  31.00 General inpatient routine service cost period (line 3 x line 31)  32.00 Average per diem private room cost differential (line 3 x line 35)  33.00 Average per diem private room cost differential (line 3 x line 35)  34.00 O Program general inpatient routine service cost periode ost applicable to the Program (line 14 x line 35)  38.00 Ag				
reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 24)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 O Total routine service charges (excluding swing-bed charges)  30.00 Average perivate room charges (excluding swing-bed charges)  30.00 Average perivate room per diem charge (line 29 + line 3)  30.00 Average peridem private room charge differential (line 3 x line 31)  27.00 General inpatient routine service cost formula (line 3 x line 31)  30.00 Average per diem private room charge differential (line 3 x line 31)  31.00 General inpatient routine service cost period (line 3 x line 31)  32.00 Average per diem private room cost differential (line 3 x line 35)  33.00 Average per diem private room cost differential (line 3 x line 35)  34.00 O Program general inpatient routine service cost periode ost applicable to the Program (line 14 x line 35)  38.00 Ag	17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
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Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   0.00   20.00   20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   3,694,831   21.00   22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line   5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line   6 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   7 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   7 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line   8 x line 20)   26.00   26.00   27.00   28.00				
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (1:00 Total general inpatient routine service cost (see instructions)  3, 694, 831 21.00  30 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  30 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  40 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  41 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  42 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  43 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  44 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  45 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  46 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  47 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)  48 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)  48 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)  48 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 31)  48 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 31)  48 Swing-bed cost applicable to NF type service after December 31 of the cost reporting period (line 9 x line 31)  48 Swing-bed cost applicable to NF type service after December 31 of the cost rep	19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  31.00 Average per diem private room per diem charge (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 34 x line 31)  38.00 Average per diem private room charge differential (line 34 x line 31)  38.00 Average per diem private room charge differential (line 34 x line 31)  38.00 Average per diem private room cost differential (line 34 x line 35)  38.00 Average per diem private room cost differential (line 34 x line 35)  38.00 Average per diem private room cost differential (line 34 x line 35)  38.00 Average per diem private room cost differential (line 34 x line 35)  38.00 Average per diem private room cost differential (line 34 x line 35)  38.00 Average per diem private room cost differential (line 34 x line 35)  38.00 Average per diem private room cost differential (line 34 x line 35)  38.00 Avera				
reporting period Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  28.00 Total swing-bed cost (see instructions)  29.00 Total swing-bed cost (see instructions)  29.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3) 30.00 Average per diem private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  37.00 Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831  37.00 Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831  37.00 Algiusted general inpatient routine service cost per diem (see instructions)  38.00 Algiusted general inpatient routine service cost per diem (see instructions)  486, 803 Algiusted general inpatient routine service cost per diem (see instructions)  487.00 Central pe	20.00		0.00	20.00
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per ivate room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Program general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Program general inpatient routine service cost (line 9 x line 38)  486,803 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average perivate room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 29 + line 3)  34.00 Average per diem private room cost differential (line 30 + line 4)  35.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  36.00 Private room cost differential adjustment (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  38.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  436,803 39.00 Average per aliem proutine service cost per diem (see instructions)  436,803 39.00 Average per aliem could be aliem (see instructions)  436,803 39.00 Average per aliem could be aliem (see instructions)  436,803 39.00 Average per aliem could be aliem could be aliem (see instructions)  436,803 39.00 Average per aliem could be aliem could be aliem (see instructions)	21. 00		3, 694, 831	21.00
5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service charges (excluding swing-bed sharges)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  36.00 Frivate room cost differential adjustment (line 3 x line 31)  37.00 General inpatient routine service cost ret of swing-bed cost and private room cost differential (line 3, 694, 831)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35)  58.80 Medically necessary private room cost dapplicable to the Program (line 14 x line 35)				
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 Reneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charges (line 29 ± line 3)  30.00 Average per vate room per diem charge (line 29 ± line 3)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential dipustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Private room cost differential dipustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 35 x line 35)  30.00 Average per diem private room cost differential (line 35 x line 35)  30.00 Average per diem private room cost differential (line 36 x line 37)  30.00 Average per diem private room cost differential (line 37 x line 37)  30.00 Average per diem private room cost differential (line 37 x line 37)  30.00 Average per diem private room cost differential (line 36 x line 37)  30.00 Average per diem private room cost differential (line 36 x line 37)  30.00 Average per diem private room cost differential (line 36 x line 37)  30.00 Average per diem private room cost different				
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 0 26.00 Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 7 8 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9	23 00		o	23 00
24.00  25.00  25.00  25.00  25.00  26.00  27.00  28.00  29.00  29.00  29.00  20	20.00		Ĭ	20.00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	24 00	, and the second	0	24 00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  436,803 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 26.00 25.00  27.00 26.00  28.00 27.00  28.00 29.00  29.00 30.00  29.00  20.00 30.00  20.00 30.00  3	21.00		Ŭ	21.00
x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  32. 00 Average semi-private room per diem charge (line 29 ÷ line 3)  33. 00 Average per diem private room charge differential (line 30 ÷ line 4)  34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00  40. 00  40. 00  40. 00  40. 00  40. 00	25 00		n	25 00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTI AL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 ÷ line 29)  30.00 Average semi-private room per diem charge (line 29 ÷ line 3)  30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per diem private room cost diffe	20.00		Ŭ	20.00
27. 00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   3,694,831   27. 00     PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00     General inpatient routine service charges (excluding swing-bed and observation bed charges)   0   28. 00     Pri vate room charges (excluding swing-bed charges)   0   29. 00     30. 00   Semi-pri vate room charges (excluding swing-bed charges)   0   30. 00     31. 00   General inpatient routine service cost/charge ratio (line 27 ÷ line 28)   0. 0000000   31. 00     32. 00   Average pri vate room per diem charge (line 29 ÷ line 3)   0. 00   32. 00     33. 00   Average semi-pri vate room per diem charge (line 30 ÷ line 4)   0. 00   33. 00     34. 00   Average per diem pri vate room charge differential (line 32 minus line 33)(see instructions)   0. 00   34. 00     35. 00   Average per diem pri vate room cost differential (line 34 x line 31)   0. 00   35. 00     36. 00   Pri vate room cost differential adjustment (line 3 x line 35)   0   36. 00     37. 00   General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36)   27 minus line 36)   PART II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   878. 88   38. 00     39. 00   Program general inpatient routine service cost per diem (see instructions)   436, 803   39. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0   40. 00	26 00	, and the second	n	26 00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30. 00 Average private room per diem charge (line 29 ÷ line 3)  30. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831)  30. 00 Agi usted general inpatient routine service cost per diem (see instructions)  30. 00 Program general inpatient routine service cost (line 9 x line 38)  436, 803 39. 00  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00  29. 00  20. 00  30.				
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831)  37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  436, 803 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 29.00  29.00 29.00  30.00 29.00  30.00 0  30.00 0  30.00 0  30.00 0  30.00 0  30.00 0  30.00 0  30.00 0  31.00 0  32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  0.00 33.00 0  33.00 0  34.00 0  35.00 Average per diem private room cost differential (line 3, 694, 831)  0.00 33.00  36.00 Private room cost differential adjustment (line 3 x line 35)  0 36.00 0  37.00 Frogram general inpatient routine service cost (line 9 x line 38)  436, 803 39.00	27.00		0, 071, 001	27.00
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  436, 803 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 30.00 30.00 30.00 0.00 30.00 0.00 31.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 33.00 0.00 0	28 00		0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 436, 803 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  37.00 Program general inpatient routine service cost (line 9 x line 38)  436, 803 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.				
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 37.00 Program general inpatient routine service cost (line 9 x line 38) 436,803 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 0.00 33.00 0.00 34.00 35.00 36.00 36.00 36.00 37.00 38.00 39.00 40.00				
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  9 Program general inpatient routine service cost (line 9 x line 38)  436, 803 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  436, 803 39.00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 694, 831)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  37.00 Program general inpatient routine service cost (line 9 x line 38)  436, 803 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  436,803 39.00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00  37.00  38.00  4878.88  38.00  496,803  496,803  496,803				
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  97.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 40.00				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  878.88 38.00 Program general inpatient routine service cost (line 9 x line 38)  436,803 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  878.88 38.00  Program general inpatient routine service cost (line 9 x line 38)  436,803 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00		3, 694, 831	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  878.88 38.00  Program general inpatient routine service cost (line 9 x line 38)  436,803 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00				
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  878.88 38.00  97.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  878.88 38.00  436,803 39.00				
39.00 Program general inpatient routine service cost (line 9 x line 38) 436,803 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
		, ,		
41.00  Total Program general inpatient routine service cost (line 39 + line 40) 436,803   41.00				40.00
	41. 00	Iotal Program general inpatient routine service cost (line 39 + line 40)	436, 803	41.00

COMPUT	FINANCIAL SYSTEMS FA ATION OF INPATIENT OPERATING COST	YETTE REGIONAL	Provi der C	CN: 15-0064 F	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 10/01/2018 To 07/15/2019	Date/Time Prep 12/18/2019 2:4	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x	
		Inpatient Cost	Inpatient Days	Diem (col. 1 + col. 2)		col. 4)	
		1. 00	2. 00	3.00	4.00	5. 00	
42. 00	NURSERY (title V & XIX only)	140, 796	23				42.00
	Intensive Care Type Inpatient Hospital Units			· ·	•		1
	INTENSIVE CARE UNIT	1, 521, 451	144	10, 565. 63	0	0	
44.00							44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	3. Line 200)			308, 103	48. 00
	Total Program inpatient costs (sum of lines			ons)		744, 906	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>		<u>,                                      </u>			
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
						_	
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fi	rom Wkst. D, s	um of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and E1)				o	52.00
53.00	Total Program inpatient operating cost exclu	,	alated non-nh	veician angeth	atist and	0	
55.00	medical education costs (line 49 minus line		erateu, non-pri	ysi ci aii allestii	etist, and	١	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0. 00	55.00
56.00	, ,					0	
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	ending 1996, i	updated and co	mpounded by the	0.00	59.00
60.00		cost renort ur	ndated by the i	market hasket		0.00	60.00
61.00	If line 53/54 is less than the lower of line				the amount by	0.00	1
01.00	which operating costs (line 53) are less that					Ĭ	01100
	amount (line 56), otherwise enter zero (see	instructions)	·		Ü		
	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.00
(4.00	PROGRAM I NPATIENT ROUTI NE SWI NG BED COST	4- 4			(6	0	(4.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through bece	ember 31 or the	e cost reporti	ng period (see	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	period (See	0	65.00
	instructions)(title XVIII only)				p = 1	-	
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 (	of the cost re	porting period	0	67.00
40.00	(line 12 x line 19)	o cooto often D	Nacamban 21 of	the cost rone	nting ported		40.00
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter L	becember 31 or	the cost repo	rting period	١	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + line	e 68)		0	69.00
, 55	PART III - SKILLED NURSING FACILITY, OTHER N		•				1
70.00	Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line						72.00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	art II column		75.00
73.00	26, line 45)	routine service	COSTS (IIOIII I	WOLKSHEEL D, F	art II, corumii		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line	76) <sup>'</sup>					77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00	Aggregate charges to beneficiaries for exces	, ,		,	==>		79. 00
80.00	Total Program routine service costs for comp		ost iimitatio	n (IIne /8 min	us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
82 NA	Reasonable inpatient routine service cost it ill tation (i		* .				83.00
82. 00 83. 00	Program inpatient ancillary services (see in		,				84.00
82. 00 83. 00 84. 00	, , , , , , , , , , , , , , , , , , , ,		ons)			1	85.00
83.00	Utilization review - physician compensation	(See Histiactic					
83. 00 84. 00		•					86.00
83. 00 84. 00 85. 00 86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS	of lines 83 th S THROUGH COST					
83. 00 84. 00 85. 00 86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions	of lines 83 th S THROUGH COST )	nrough 85)			783	87. 00
83. 00 84. 00 85. 00 86. 00 87. 00 88. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions	of lines 83 th S THROUGH COST ) diem (line 27 ÷	rough 85) - line 2)			783 878. 88 688, 163	87. 00 88. 00

Health Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 10/01/2018 To 07/15/2019		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	104, 773	3, 694, 831	0. 02835	688, 163	19, 514	90.00
91.00 Nursing School cost	0	3, 694, 831	0.00000	00 688, 163	0	91.00
92.00 Allied health cost	0	3, 694, 831	0.00000	688, 163	0	92.00
93.00 All other Medical Education	0	3, 694, 831	0. 00000	688, 163	0	93.00

Health Financial Systems FAYETTE REGIONAL				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0064	Peri od: From 10/01/2018	Worksheet D-3	
			To 07/15/2019		nared.
			10 077 107 2017	12/18/2019 2:	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					ļ
30. 00   03000   ADULTS & PEDI ATRI CS			949, 627		30.00
31. 00   03100   I NTENSI VE CARE UNI T			168, 764		31.00
40. 00   04000   SUBPROVI DER - 1 PF			0		40.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
42. 00   04200   SUBPROVI DER			0		42.00
43. 00   04300   NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATING ROOM		0. 47462			
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 23346			
60. 00   06000   LABORATORY		0. 20463			
65. 00 06500 RESPI RATORY THERAPY		0. 28104			
66. 00   06600   PHYSI CAL THERAPY		0. 78325			
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		0	69.00
69. 01   06901   CARDI AC   REHAB		1. 01159		0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 48547			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 63506			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 38069	98 400, 982	152, 653	73.00
OUTPATIENT SERVICE COST CENTERS					
91. 00   09100   EMERGENCY		0. 21634			
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 38095		0	
93. 00   04050   CLINIC		0. 45691		l	
93. 01   04950   BI C		0.00000		0	93. 01
93. 05   04954   PODI ATRY		0. 00000	00 0	0	93.05
OTHER REIMBURSABLE COST CENTERS					ļ
95. 00 09500 AMBULANCE SERVICES					95.00
200 00 Total (sum of lines 50 through 94 and 96 through 98)		1	2 779 690	762 649	1200 00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

762, 649 200. 00 201. 00 202. 00

2, 779, 690

2, 779, 690

200. 00 201. 00 202. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0064	Peri od:	Worksheet D-3	1
			From 10/01/2018 To 07/15/2019	Date/Time Pre 12/18/2019 2:	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			138, 850		30.0
31. 00 03100 I NTENSI VE CARE UNI T			0		31.0
40. 00   04000   SUBPROVI DER -   PF			0		40.0
41. 00   04100   SUBPROVI DER -   RF			0		41.0
42. 00   04200   SUBPROVI DER			0		42.0
43. 00 04300 NURSERY			0		43.0
ANCILLARY SERVICE COST CENTERS		0.4747	27 00 404	40.750	
50. 00   05000   OPERATING ROOM		0. 47462		43, 752	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 2334			
60. 00   06000   LABORATORY		0. 20463			
65. 00 06500 RESPI RATORY THERAPY		0. 2810		14, 209 0	1
66. 00  06600 PHYSI CAL THERAPY 69. 00  06900 ELECTROCARDI OLOGY		0. 7832		ı .	69.0
69. 01   06900   ELECTROCARDI OLOGY 69. 01   06901   CARDI AC   REHAB		1. 0115		0 0	69.0
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4854		44, 637	
71.00 OTTOO MEDICAL SUPPLIES CHARGED TO PATTENTS  72.00 OT200 IMPL. DEV. CHARGED TO PATTENTS		0. 4654		44,037	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3806		76, 842	
OUTPATIENT SERVICE COST CENTERS		0.3000	201, 040	70,042	73.0
91. 00   09100  EMERGENCY		0. 2163	132, 568	28, 680	91.0
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 3809!		20,000	
93. 00   04050  CLINIC		0. 4561		466	
93. 01   04950   BI C		0. 00000		0	1
93. 05   04954   PODI ATRY		0.00000		0	
OTHER REIMBURSABLE COST CENTERS		0.0000	55, 0		1 ,0.0
95. 00 09500 AMBULANCE SERVICES					95.0
200 00 Total (sum of lines 50 through 94 and 96 through 98)			1 051 148	308 103	

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

308, 103 200. 00 201. 00 202. 00

1, 051, 148 0

1, 051, 148

200. 00 201. 00 202. 00

	Financial Systems FAYETTE REGIONAL				u of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
		Component		From 10/01/2018 To 07/15/2019		nared:
		Component	0014. 15 0004	10 077 137 2017	12/18/2019 2:	44 pm
		Ti tl	e XIX	Swing Beds - SNF		
	Cost Center Description		Ratio of Cost	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				ı	
30.00	03000 ADULTS & PEDIATRICS			0		30.00
	03100 INTENSIVE CARE UNIT			0		31.00
	04000 SUBPROVI DER - I PF			0		40.00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
42.00	04200 SUBPROVI DER			0		42.00
43. 00	04300 NURSERY			0		43.00
F0 00	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0.00000			
	05400 RADI OLOGY-DI AGNOSTI C		0.00000		1	54.00
	06000 LABORATORY		0.00000		0	60.00
65. 00	06500 RESPI RATORY THERAPY		0.00000		0	65.00
	06600 PHYSI CAL THERAPY		0.00000		0	66.00
	06900 ELECTROCARDI OLOGY		0.00000		0	69.00
	06901 CARDI AC REHAB		0.00000		0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		1	72.00
/3.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS		0.00000	0 0	0	73. 00
01 00	09100 EMERGENCY		0.00000	ol o	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.00000			91.00
	04050 CLINIC		0.00000		0	93.00
	04950 BI C		0.00000		Ĭ	93.00
	04954 PODI ATRY		0.00000		1	93.05
73.03	OTHER REIMBURSABLE COST CENTERS		0.00000	0		73.03
95 00	09500 AMBULANCE SERVICES					95.00
200.00			1		I	200.00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

0 200. 00 201. 00 202. 00

0

200. 00 201. 00 202. 00

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	u of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019	Worksheet E Part A Date/Time Prepared: 12/18/2019 2:44 pm

			10 07/13/2019	12/18/2019 2:	
		Title XVIII	Hospi tal	PPS	
	DART A LABORTIENT HOODITAL CERVICES HARRED LABOR			1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1. 00 1. 01	DRG amounts other than outlier payments for discharges occurring	og prior to October 1 (	200	0	1.00
1.01	instructions)	ig piror to october i (	366	0	1.01
1. 02	DRG amounts other than outlier payments for discharges occurring	ng on or after October	1 (see	959, 575	1. 02
	instructions)	3	(	, , ,	
1.03	DRG for federal specific operating payment for Model 4 BPCI for	di scharges occurri ng	prior to October	0	1.03
	1 (see instructions)				
1. 04	DRG for federal specific operating payment for Model 4 BPCI for	di scharges occurri ng	on or after	0	1. 04
2. 00	October 1 (see instructions) Outlier payments for discharges. (see instructions)				2. 00
2. 00	Outlier reconciliation amount			0	2.00
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)		0	2.02
2. 03	Outlier payments for discharges occurring prior to October 1 (s	•		0	2.03
2. 04	Outlier payments for discharges occurring on or after October 1			12, 683	
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost report	ing period (see instru	ctions)	42. 28	4.00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the most	recent cost reporting	period ending on	0. 00	5. 00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet the	critoria for an add o	n to the can for	0. 00	6. 00
0.00	new programs in accordance with 42 CFR 413.79(e)	e cirteria for all add-c	in to the cap roll	0.00	0.00
7. 00	MMA Section 422 reduction amount to the IME cap as specified ur	nder 42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 4			0.00	7. 01
	cost report straddles July 1, 2011 then see instructions.				
8.00	Adjustment (increase or decrease) to the FTE count for allopath			0. 00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79	9(c)(2)(iv), 64 FR 2634	0 (May 12,		
0.01	1998), and 67 FR 50069 (August 1, 2002).	to under \$ FEO2 of the	ACA If the sect	0.00	0.01
8. 01	The amount of increase if the hospital was awarded FTE cap slot report straddles July 1, 2011, see instructions.	.S under 9 5503 of the	ACA. II the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slot	s from a closed teachi	ng hospital	0. 00	8. 02
0.02	under § 5506 of ACA. (see instructions)		ng noopi tai	0.00	0.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	s (8, 8,01 and 8,02) (	see	0.00	9. 00
	instructions)				
10.00	FTE count for allopathic and osteopathic programs in the currer	nt year from your recor	ds	0. 00 0. 00	10.00
	1 9				
12.00	Current year allowable FTE (see instructions)				12. 00 13. 00
14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on or after Ser	tember 30 1997	0.00	
14.00	otherwise enter zero.	chaca on or arter sep	Telliber 30, 1777,	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0. 00	16.00
17. 00	Adjustment for residents displaced by program or hospital closu	ıre			17. 00
	Adjusted rolling average FTE count				18. 00
	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	
	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
21. 00 22. 00	IME payment adjustment (see instructions)			0.000000	21.00
	IME payment adjustment - Managed Care (see instructions)			0	
22.0.	Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		-	22.0.
23.00	Number of additional allopathic and osteopathic IME FTE resider		FR 412. 105	0.00	23.00
	(f)(1)(iv)(C).	·			
24.00	IME FTE Resident Count Over Cap (see instructions)			0. 00	
25. 00	If the amount on line 24 is greater than -O-, then enter the lo	ower of line 23 or line	24 (see	0. 00	25. 00
27 00	instructions)			0. 000000	2/ 00
26. 00	Resident to bed ratio (divide line 25 by line 4)  IME payments adjustment factor. (see instructions)			0. 000000	
	IME add-on adjustment amount (see instructions)			0.000000	28.00
	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0	1
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 01
	Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days (see instruc	ti ons)	10. 58	
	Percentage of Medicaid patient days (see instructions)			30. 35	
32.00				40. 93	
33.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			12. 00 28, 787	
J4. UU	The shi obour contacts share and astillent (See This tructions)		∠ŏ, /ŏ/	34.00	

CALCUL	Financial Systems FAYETTE REGIONAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0064	Peri od:	u of Form CMS-2 Worksheet E	
			From 10/01/2018 To 07/15/2019		nared:
				12/18/2019 2:	
		Title XVIII	Hospital Prior to 10/1	PPS	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)			8, 272, 872, 447	
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, en	ter zero on this line) (se	0. 00000000	0. 000095674 791, 499	35. 01 35. 02
33. 02	instructions)				
35. 03	03 Pro rata share of the hospital uncompensated care payment amount (see instructions)				35. 03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line 35 Additional payment for high percentage of ESRD beneficiary		624, 525		36.00
40. 00	Total Medicare discharges on Worksheet S-3, Part I excludin		0		40.00
	652, 682, 683, 684 and 685 (see instructions)				
			Before 1/1	On/After 1/1	
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682,	683 684 an 685 (see	1.00	1. 01	41.00
41.00	instructions)	000, 004 an 000. (300		J	41.00
41. 01	Total ESRD Medicare covered and paid discharges excluding M	S-DRGs 652, 682, 683, 684	0	0	41.01
42.00	an 685. (see instructions)	Lify for edimetment)	0.00		42.00
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0.00		42. 00 43. 00
.0.00	instructions)	002, 000, 00. a 000. (000			10.00
44. 00	Ratio of average length of stay to one week (line 43 divide	d by line 41 divided by 7	0. 000000		44.00
45. 00	days) Average weekly cost for dialysis treatments (see instruction	ine)	0.00	0.00	45. 00
	Total additional payment (line 45 times line 44 times line		0.00	0.00	46.00
47.00	Subtotal (see instructions)	ŕ	1, 625, 570		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48. 00
	only. (see instructions)			Amount	
				1. 00	
49.00	Total payment for inpatient operating costs (see instruction			1, 625, 570	
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I Exception payment for inpatient program capital (Wkst. L, P			79, 260 0	50.00 51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4,			0	52.00
53.00	Nursing and Allied Health Managed Care payment			0	53.00
54.00	4.00 Special add-on payments for new technologies 4.01 Islet isolation add-on payment				54.00 54.01
55. 00	55.00 Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55.00
56. 00	66.00 Cost of physicians' services in a teaching hospital (see intructions)				56.00
57.00					
59.00	8.00   Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200) 9.00   Total (sum of amounts on lines 49 through 58)				58. 00 59. 00
60.00	Primary payer payments			1, 704, 830 0	60.00
	Total amount payable for program beneficiaries (line 59 min	us line 60)		1, 704, 830	
61. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			174, 636	
61. 00 62. 00				28, 308	63. 00 64. 00
61. 00 62. 00 63. 00					
61. 00 62. 00 63. 00 64. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			18, 400	65.00
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in	structions)		28, 308	66.00
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63)	•		28, 308 1, 548, 594	66. 00 67. 00
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo	r applicable to MS-DRGs (s		28, 308 1, 548, 594 0	66. 00 67. 00 68. 00
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63)	r applicable to MS-DRGs (s		28, 308 1, 548, 594	66. 00 67. 00 68. 00 69. 00
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon	r applicable to MS-DRGs (s). (For SCH see instructionstration) adjustment (see	ns)	28, 308 1, 548, 594 0 0 0 0	66. 00 67. 00 68. 00 69. 00 70. 00
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see	ns)	28, 308 1, 548, 594 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 70. 00 70. 50
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only)	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see	ns)	28, 308 1, 548, 594 0 0 0 0	66. 00 67. 00 68. 00 69. 00 70. 00 70. 87 70. 88
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see in structions)	ns)	28, 308 1, 548, 594 0 0 0 0 0	66. 00 67. 00 68. 00 70. 00 70. 87 70. 88 70. 89
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 50 70. 87 70. 88 70. 89 70. 91	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see in structions)	ns)	28, 308 1, 548, 594 0 0 0 0 0 0	66. 00 67. 00 68. 00 70. 00 70. 50 70. 88 70. 88 70. 90
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see in structions)	ns)	28, 308 1, 548, 594 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 91 70. 92
61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 70. 00 70. 50 70. 87 70. 88 70. 89 70. 91 70. 92 70. 93	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see in Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices fo Outlier payments reconciliation (sum of lines 93, 95 and 96 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demon Demonstration payment adjustment amount before sequestratio SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	r applicable to MS-DRGs (s). (For SCH see instruction stration) adjustment (see in structions)	ns)	28, 308 1, 548, 594 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 87 70. 88 70. 99 70. 91 70. 92 70. 93

	Financial Systems FAYETTE REGIONAL HE				u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019		pared:
		Title	: XVIII	Hospi tal	PPS	44 рііі
				′ (yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
	the corresponding federal year for the period prior to 10/1)					
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i the corresponding federal year for the period ending on or af			2019	360, 725	70. 97
70. 98	Low Volume Payment-3				0	
70. 99	HAC adjustment amount (see instructions)				20, 614	
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			1, 884, 556	71.00
71. 01	Sequestration adjustment (see instructions)				37, 691	•
	Demonstration payment adjustment amount after sequestration				0	
	Interim payments				1, 553, 366	
73. 00	Tentative settlement (for contractor use only)				0	
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.073)				293, 499	
75. 00	Protested amounts (nonallowable cost report items) in accorda CMS Pub. 15-2, chapter 1, §115.2	nce with			0	75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)		1			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	of 2.03			0	
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see instr				0	92.00
	Capital outlier reconciliation adjustment amount (see instruc				0	
	The rate used to calculate the time value of money (see instr	,			0.00	
	Time value of money for operating expenses (see instructions)				0	
96.00	Time value of money for capital related expenses (see instruc	tions)		Dri or to 10/1	On/After 10/1	96.00
				1.00	2. 00	
	HSP Bonus Payment Amount			1.00	2.00	
100.00	HSP bonus amount (see instructions)				0	100.00
	HVBP Adjustment for HSP Bonus Payment			<b>"</b>		
101.00	HVBP adjustment factor (see instructions)				0. 0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instruction	s)			0	102.00
	HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)				0. 0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions				0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonst	ration) Adjı	ustment			
200.00	Is this the first year of the current 5-year demonstration pe	riod under	the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.					ļ
	Cost Reimbursement					
	Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	e 49)				201.00
	Medicare discharges (see instructions)					202.00
203.00	Case-mix adjustment factor (see instructions)	£:1	-6 -11-			203. 00
	Computation of Demonstration Target Amount Limitation (N/A in	Tirst year	of the curre	ent 5-year demons	stration	
204.00	peri od)					204 00
	Medicare target amount Case-mix adjusted target amount (line 203 times line 204)					204. 00 205. 00
	Medicare inpatient routine cost cap (line 202 times line 205)					205.00
200. UU	production of the production of the cost cap (Title 202 tilles Title 205)			1		1200. UU

207. 00

208. 00

209.00

210. 00 211. 00

212. 00 213. 00

218. 00

210.00 Reserved for future use
211.00 Total adjustment to Medicare IPPS payments (see instructions)

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

Adjustment to Medicare Part A Inpatient Reimbursement
207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

213.00 Low-volume adjustment (see instructions)
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 15-0064

Period: Worksheet E From 10/01/2018 Part A Exhibit 4 To 07/15/2019 Date/Time Prepared:

Title XVIII	
Ine	
1.00   DRG amounts other than outlier   1.00   0   0   0   0   0   0   0   0   0	
Dayments   DRG amounts other than outlier   DRG amounts other than outlier   DRG amounts other than outlier   DRG amounts for discharges   DRG amounts other than outlier   DRG amounts off   DRG amounts	
1.01   DRG amounts other than outlier   1.01	0 1.00
1.02   DRG amounts other than outlier payments for discharges occurring on or after October 1   1.03   DRG for Federal specific operating payment for Model 4   BPCl occurring or or after October 1   1.04   DRG for Federal specific operating payment for Model 4   BPCl occurring on or after October 1   1.04   DRG for Federal specific operating payment for Model 4   BPCl occurring on or after October 1   1.04   DRG for Federal specific operating payment for Model 4   BPCl occurring on or after October 1   1.04   DRG for Federal specific operating payments for October 1   1.04   DRG for Federal specific operating payments for October 1   1.05   DRG for Federal specific operating payments for October 1   1.04   DRG for Federal specific operating payments for October 1   1.05   DRG for Federal specific operating prior to October 1   1.05   D	0 1.01
Operating payment for Model 4   BPCI occurring prior to 0   October 1	1.02
1. 04       DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1       1. 04       0	0 1.03
2.00       Outlier payments for discharges (see instructions)       2.00       0 <td>0 1.04</td>	0 1.04
2.01  Outlier payments for discharges for Model 4 BPCI	2.00
2.02	0 2.01
2.03	0 2.02
3.00   Operating outlier   2.01   0   0   0   0   0   0   0   0   0	0 2.03
4.00 Managed care simulated 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 3.00
5.00 Amount from Worksheet E, Part 21.00 0.000000 0.000000 0.000000 0.000000 0.000000	0 4.00
6.00   IME payment adjustment (see   22.00   0   0   0	5.00
	0 6.00
instructions) 6.01   IME payment adjustment for 22.01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 6.01
instructions)	_
7.00   IME payment adjustment factor   27.00   0.000000   0.000000   0.000000   0.000000	7.00
(see instructions) 8.00   IME adjustment (see	0 8.00
instructions) 8.01   IME payment adjustment add on for managed care (see instructions)   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 8.01
9.00 Total IME payment (sum of 29.00 0 0 0 0 0 0 0 0	0 9.00
9.01 Total IME payment for managed 29.01 0 0 0 0 0 care (sum of lines 6.01 and 8.01)	0 9.01
Disproportionate Share Adjustment	
10. 00   Allowable disproportionate   33. 00   0. 1200	10.00
11.00 Disproportionate share 34.00 28,787 0 0 28,787 28 adjustment (see instructions)	11.00
11.01 Uncompensated care payments 36.00 624,525 0 0 624,525 624	11. 01
Additional payment for high percentage of ESRD beneficiary discharges  12.00 Total ESRD additional payment	0 12.00
(see instructions) 47.00 1,625,570 0 0 1,625,570 1,625	
14.00 Hospital specific payments 48.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 14.00
15. 00 Total payment for inpatient 49. 00 1, 625, 570 0 1, 625, 570 1, 625 instructions)	70 15 00

Heal th	Financial Systems	F.A	YETTE REGIONAL	HEALIH SYSIEM		In Lie	u of Form CMS-2	2552-10
LOW VO	LUME CALCULATION EXHIBIT 4			Provi der C	CN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After	through 4)	
			·			10/01		
		0	1. 00	2. 00	3.00	4. 00	5. 00	
16. 00	Payment for inpatient program	50.00	79, 260	0		0 79, 260	79, 260	16, 00
	capital (from Wkst. L, Pt. I, if applicable)						,	
17. 00	Special add-on payments for new technologies	54. 00	0	0		0 0	0	
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from	68. 00	0	0		0	0	17. 02
	manufacturers for replaced devices for applicable MS-DRGs							
18. 00	Capital outlier reconciliation adjustment amount (see	93. 00	0	0		0 0	0	18.00
10 00	instructions) SUBTOTAL			0		0 1, 704, 830	1 704 020	10 00
19. 00	SUBTUTAL	W/C L Line	(Amounto from	U		0 1, 704, 830	1, 704, 830	19.00
		W/S L, line	(Amounts from					
		0	L) 1. 00	2. 00	3. 00	4. 00	5. 00	
20.00	Carital DDC ather than authing	1, 00		2.00	3.00			20.00
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00	78, 387 0	0		0 78, 387 0 0	78, 387 0	1
21. 00	Capital DRG outlier payments	2. 00	873	n		0 873	873	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.000	0.0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	79, 260	0		0 79, 260	79, 260	26. 00
		W/S E, Part A	(Amounts to					
		l i ne	E, Part A)					
		0	1. 00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 00000	0. 211590		27.00
28. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 96				0	0	28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				360, 725	360, 725	29. 00
100. 00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

Provider CCN: 15-0064

Peri od:

Part A Exhibit 5

From 10/01/2018 07/15/2019 Date/Time Prepared: 12/18/2019 2:44 pm Title XVIII Hospi tal PPS Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 0 0 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 959, 575 959, 575 959, 575 1 02 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 2.01 **BPCI** 2.02 2.02 Outlier payments for discharges occurring 2.03 0 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 12, 683 12, 683 2.03 0 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 C 0 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 0.000000 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 6.00 C 0 6.01 IME payment adjustment for managed care (see 22.01 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 0 0 IME payment adjustment add on for managed O 28 01 r 0 8 01 8 01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 9.00 0 Total IME payment for managed care (sum of 9.01 29.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1200 0.1200 0.1200 10.00 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 28, 787 0 28, 787 28, 787 11.00 instructions) 624, 525 11.01 36 00 624, 525 0 624, 525 Uncompensated care payments 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 46.00 0 12.00 instructions) Subtotal (see instructions) 47.00 1, 625, 570 13.00 0 1, 625, 570 1,625,570 13.00 14.00 Hospital specific payments (completed by SCH 48.00  $\cap$ 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 1, 625, 570 15 00 49 00 1,625,570 O 1, 625, 570 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 79, 260 0 79, 260 79, 260 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 0 0 17.00 0 Net organ acquisition cost 17.01 17.01 17.02 Credits received from manufacturers for 68.00 0 Λ 17.02 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 0 18.00 amount (see instructions) 19.00 SUBTOTAL 1, 704, 830 1, 704, 830 19.00 0

Heal th	Financial Systems FA	AYETTE REGIONAL	HEALTH SYSTEM		In lie	u of Form CMS-2	2552_10
	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA			CN: 15-0064 F	Period: From 10/01/2018 To 07/15/2019	Worksheet E Part A Exhibi	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3. 00	4.00	
20.00	Capital DRG other than outlier	1. 00	78, 387	(	78, 387	78, 387	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	873	(	873	873	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(	0	0	23.00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0000	0. 0000	0.0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	(	0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	79, 260	(	79, 260	79, 260	26. 00
	, , , , , , , , , , , , , , , , , , , ,	Wkst. E. Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		0	1. 00	2. 00	3.00	4. 00	
27. 00							27. 00
28.00	Low volume adjustment prior to October 1	70. 96	0	(		0	28. 00
29.00	Low volume adjustment on or after October 1	70. 97	360, 725		360, 725	360, 725	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-2, 997	(	-2, 997	-2, 997	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0	(	0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-1, 152	(	-1, 152	-1, 152	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	(	0	0	31. 01
						(Amt to	

0 70. 99 1.00

2.00

0

3.00

20, 614

(Amt. to Wkst. E, Pt. A) 4.00

20, 614

32.00

100.00

32.00 HAC Reduction Program adjustment (see

instructions)

100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	FAYETTE REGIONAL HEALTH	H SYSTEM	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Prov		From 10/01/2018 To 07/15/2019	Worksheet E Part B Date/Time Prepared: 12/18/2019 2:44 pm
		T' 11 . \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11	DDC

PART B. WEDICAL MOLOTHER HEALTH SERVICES   1.00				10 077 107 2017	12/18/2019 2:	
PART B MEDICAL AND OTHER HEALTH SERVICES   1.00   Moderal and other services (see imburated under OPPS (see imstructions)   3.85,766   2.00   2.00   Moderal and other services reinbursed under OPPS (see instructions)   3.85,766   2.00			Title XVIII	Hospi tal	PPS	
PART B MEDICAL AND OTHER HEALTH SERVICES   1.00   Moderal and other services (see imburated under OPPS (see imstructions)   3.85,766   2.00   2.00   Moderal and other services reinbursed under OPPS (see instructions)   3.85,766   2.00						
Medical and other services (see instructions)		F			1. 00	
Medical and other services reinbursed under OPPS (see Instructions)   3,887, 966   2,00	4 00				40.5/4	4 00
Deep Computer   1.00			unc)			
0.00   1   1   1   1   1   1   1   1   1			1115)			
Outlier reconciliation amount (see instructions)						
Enter the hospital specific payment to cost ratio (see instructions)						
Line 2 times line 5		,	ons)			
1.00   Continuent   Continuen			,			
	7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
0.00   organ acquisitions   0   0.00	8.00	Transitional corridor payment (see instructions)			0	8.00
1.00   Total cost (sum of lines 1 and 10) (see instructions)   1.9,564	9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9. 00
Computation of LESSER of COST OR CHARGES   Reasonable charges   Reasonable charges   St. 200   Ancil lary service charges (from Wist. D-4, Pt. III, col. 4, line 69)   51,300   13,0	10.00	Organ acqui si ti ons			0	10.00
Reasonable charges   1.00   Ancil lary service charges   1.00   Ancil lary service charges   1.00   Ancil lary service charges (sum of lines 12 and 13)   12.00   Ancil lary service charges (sum of lines 12 and 13)   13.00   13.0	11.00				19, 564	11.00
12.00   Ancil lary service charges   51,320   12.00   10.11   10.00   10.11   10.00   10.11   10.00   10.11   10.00   10.11   10.00   10.11   10.00   10.11   10.00   10.11   10.00   10.11   10.00   10.11   10.00						
13.00   Organ acquisition charges (from Mikst. D-4, Pt. III, col. 4, line 69)   0   13.00   13.00   Coustomary charges (sum of lines 12 and 13)   15.00   Aggregate amount actually collected from patients liable for payment for services on a chargebasis   0   15.00   Aggregate amount actually collected from patients liable for payment for services on a chargebasis   0   16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00   1		Reasonabl e charges				
1.0   Total reasonable charges (sum of lines 12 and 13)   1.0						
Customary charges   Customary charges   0   15.00   Agrounts actually collected from patients   Iable for payment for services on a charge basis   0   16.00   Amounts that would have been read   Iacd from patients   Iable for payment for services on a chargebasis   0   16.00   Amounts that would have been read   Iacd from patients   Iable for payment for services on a chargebasis   0   16.00   Amounts that would have been read   Iacd from patients   Iable for payment for services on a chargebasis   0   16.00   17.00			: 69)		-	
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00	14.00				51, 320	14.00
16. 00   Amounts that would have been realized from patients   liable for payment for services on a chargebasis   had such payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.00	45.00					45.00
had such payment been made in accordance with 42 CFR \$413.13(e)		, , ,		•	-	
17.00	16.00		ayment for services o	n a cnargebasis	01	16.00
18.00   Total customary charges (see instructions)   51,320   18.00	17 00	' '			0.000000	17 00
19. 00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   31,756   19. 00						
Instructions		,	if line 18 eveneds li	no 11) (soo		
20.00   Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see   0   20.00   19.564   21.00   22.00   22.00   23.00   25.0	17.00		II IIIle 18 exceeds II	116 11) (366	31, 750	17.00
Instructions   19,664   21.00   10   10   10   10   10   10   10	20 00		if line 11 exceeds li	ne 18) (see	0	20 00
21.00   Lesser of cost or charges (see instructions)   19, 564   21.00   22.00   22.00   Cost of physicians' services in a teaching hospital (see instructions)   0.22.00   22.00	20.00		TT TIME TT EXCECUS TT	110 10) (300	١	20.00
22.00   Interns and residents (see instructions)   0   22.00   23.00   23.00   25 of physlcians' services in a teaching hospital (see instructions)   0   23.00   23.00   20	21. 00	·			19, 564	21.00
23.00   Cost of physicians' services in a teaching hospital (see instructions)   2.3.00   2.000   2.		,				
COMPUTATION OF REIMBURSEMENT SETTLEMENT	23.00	, , ,	tions)		0	23.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	•		2, 670, 487	24.00
26.00         Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)         601,483         26.00           27.00         Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)         2,088,568         27.00           28.00         Direct graduate medical education payments (from Wkst. E-4, line 36)         0         28.00           30.00         Subtotal (sum of lines 27 through 29)         2,088,568         30.00           31.00         Primary payer payments         801         31.10           32.00         Subtotal (line 30 minus line 31)         2,087,767         32.00           ALLOMABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)         33.00         Composite rate ESRD (from Wkst. I-5, line 11)         0         33.00           36.00         Allowable bad debts (see instructions)         116,801         34.00           37.00         Subtotal (sum of lines 27 through 29)         116,801         34.00           38.00         Composite rate ESRD (from Mkst. I-5, line 11)         0         33.00           38.00         Allowable bad debts (see instructions)         116,801         34.00           38.00         Allowable bad debts (see instructions)         116,801         36.00           38.00         MSP-LCC reconciliation amount fr		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
27.00   Subtotal [(Iines 21 and 24 minus the sum of Iines 25 and 26) plus the sum of Iines 22 and 23] (see instructions)   28.00   28.00   29.00   ESRD direct medical education payments (from Wkst. E-4, line 50)   0 28.00   29.00   29.00   29.00   20.00   29.0	25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
Instructions   Direct graduate medical education payments (from Wkst. E-4, line 50)   Direct graduate medical education costs (from Wkst. E-4, line 36)   O 28.00   O 29.00	26.00	Deductibles and Coinsurance amounts relating to amount on line 2	4 (for CAH, see instr	uctions)	601, 483	26. 00
28. 00   Direct graduate medical education payments (From Wkst. E-4, line 50)   28. 00   29. 00   ESRD direct medical education costs (From Wkst. E-4, line 36)   29. 00   29. 00   30. 00   Subtotal (sum of lines 27 through 29)   2, 088, 568   30. 00   29. 00   31. 00   Primary payer payments   2, 087, 767   32. 00   20. 00	27.00		s the sum of lines 22	and 23] (see	2, 088, 568	27. 00
29.00   ESRD diffect medical education costs (from Wkst. E-4, line 36)   29.00   30.00   Subtotal (sum of lines 27 through 29)   2,088,568   30.00   31.00   Primary payer payments   801   31.00   32.00   All Composite rate ESRD (from Wkst. I-5, line 11)   2,087,767   32.00   33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   33.00   All lowable bad debts (see instructions)   116,801   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   116,801   35.00   Adjusted reimbursable bad debts (see instructions)   116,801   35.00   Adjusted reimbursable bad debts (see instructions)   116,801   36.00   37.00   Subtotal (see instructions)   116,801   36.00   38.00   MI-0wable bad debts for dual eligible beneficiaries (see instructions)   2,163,688   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.50   0   0   0   0   0   0   0   0   0						
30.00   Subtotal (sum of lines 27 through 29)   2,088,568   30.00   Primary payer payments   801   31.00   2,087,767   32.00   32.00   33.00   2,087,767   32.00   33.00   33.00   34.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   33.00   Allowable bad debts (see instructions)   116,801   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   116,801   36.00   37.00   38.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   2,163,688   37.00   39.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.90   Pioneer ACO demonstration payment adjustment (see instructions)   0   39.90   39.90   RECOVERY OF ACCELERATED DEPRECIATION   0   39.90   39.90   Subtotal (see instructions)   2,163,688   40.01   40.01   5equestration adjustment (see instructions)   2,163,688   40.01   40.01   5equestration payment adjustment amount after sequestration   2,163,688   40.01   40.01   5equestration payment adjustment amount after sequestration   2,163,688   40.01   40.01   5equestration payment adjustment amount after sequestration   2,163,688   40.01   40.01   5equestration payment adjustment amount after sequestration   2,163,688   40.01   40.02   Demonstration payment adjustment amount after sequestration   2,163,688   40.01   40.02   4			50)		-	
31.00   Primary payer payments   30.1   31.00   32.00   Subtotal (I in e 30 mi nus line 31)   2.087,767   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I - 5, line 11)   0   33.00   33.00   Allowable bad debts (see instructions)   116,801   34.00   35.00   Allowable bad debts (see instructions)   75,921   35.00   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   116,801   36.00   37.00   Subtotal (see instructions)   2,163,688   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   39.90   79		,			-	
32.00   Subtotal (ine 30 minus line 31)   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, line 11)   0   33.00   34.00   Allowable bad debts (see instructions)   116,801   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   116,801   36.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   116,801   36.00   37.00   Subtotal (see instructions)   116,801   36.00   37.00   Subtotal (see instructions)   2,163,688   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.50   99.00   07   10   10   10   10   10   10		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00						
33.00   Composite rate ESRD (from Wkst. I-5, line 11)   0   34.00   Allowable bad debts (see instructions)   116.801   34.00   34.00   Allowable bad debts (see instructions)   75.921   35.00   34.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   116.801   36.00   37.00   Subtotal (see instructions)   2, 163.688   37.00   Subtotal (see instructions)   2, 163.688   37.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   Ploneer ACO demonstration payment adjustment (see instructions)   39.97   Demonstration payment adjustment amount before sequestration   0   39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0   39.99   39.99   RECOVERY OF ACCELERATED DEPRECIATION   2, 163.688   40.00   40.01   Sequestration adjustment (see instructions)   2, 163.688   40.00   40.02   Demonstration payment adjustment amount after sequestration   2, 163.688   40.00   40.02   Demonstration payment adjustment amount after sequestration   2, 112, 446   41.00   42.00   Tentative settlement (for contractors use only)   42.00   Tentative settlement (for contractors use only)   7, 968   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   44.00   Frotested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0   0   0.00	32.00		`		2,087,767	32.00
34.00	22 00	,	)		0	22 00
35.00   Adjusted reimbursable bad debts (see instructions)   75, 921   35.00   30.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   116, 801   36.00   37.00   Subtotal (see instructions)   2, 163, 688   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0.38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0.39.00   39.50   Pioneer ACO demonstration payment adjustment (see instructions)   0.39.97   39.98   39.99   Partial or full credits received from manufacturers for replaced devices (see instructions)   0.39.97   39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0.39.99   40.00   Sequestration adjustment (see instructions)   43.274   40.01   40.02   Demonstration payment adjustment amount after sequestration   43.274   40.01   40.02   Centrality esettlement (for contractors use only)   2, 112, 446   41.00   41.00   Interim payments   2, 112, 446   41.00   42.00   43.00   Balance due provider/program (see instructions)   7, 968   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{2}\$   515.2   70 BE COMPLETED BY CONTRACTOR   0.90.00   0.00					-	
36.00		,				
37. 00   Subtotal (see instructions)   2, 163, 688   37. 00   38. 00   MSP-LCC reconciliation amount from PS&R   0   38. 00   39. 97   39. 98   39. 00   39. 97   39. 98   39. 00   39. 99   39. 00   39.			tions)			
38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACC demonstration payment adjustment (see instructions) 39.57 Pomonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2,163,688 40.00 40.01 Sequestration adjustment (see instructions) 2,163,688 40.00 40.02 Demonstration payment adjustment amount after sequestration 43,274 40.01 40.02 Demonstration payments 40,002 Demonstration payments 40,003 Demonstration payment adjustment amount after sequestration 42.00 Tentative settlement (for contractors use only) 42.00 Tentative settlement (for contractors use only) 7,968 43.00 43.00 Bal ance due provider/program (see instructions) 7,968 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 91.50  90.00 Original outlier amount (see instructions) 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 91.00 92.00 The rate used to calculate the Time Value of Money 92.00 93.00 Time Value of Money (see instructions) 93.00						
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 Pi oneer ACO demonstration payment adj ustment (see instructions) 39. 97 Demonstration payment adj ustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adj ustment (see instructions) 40. 02 Demonstration payment adj ustment amount after sequestration 40. 01 Interim payments 41. 00 Interim payments 42. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Bal ance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{\fra						
39.50 Pi oneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.97 ay.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Subtotal (see instructions) 40.00 Subtotal (see instructions) 40.01 Demonstration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  \$\frac{1}{2}\$ 115.2  \$\frac{1}{2}\$ TO BE COMPLETED BY CONTRACTOR  90.00 Outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 39.97 0 39.98 Time Value of Money (see instructions) 0 39.98 0 39.97 0 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 0 39.99 0 39.99 0 39.99 0 39.99 0 39.90						
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions)  39. 98 RECOVERY OF ACCELERATED DEPRECIATION  40. 00 Subtotal (see instructions)  40. 01 Sequestration adjustment (see instructions)  40. 02 Demonstration payment adjustment amount after sequestration  41. 00 Interim payments  42. 00 Tentative settlement (for contractors use only)  43. 00 Balance due provider/program (see instructions)  44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44. 00  91. 00 Original outlier amount (see instructions)  90. 00 Original outlier amount (see instructions)  70. 00 The rate used to calculate the Time Value of Money  91. 00 Time Value of Money (see instructions)  92. 00 Time Value of Money (see instructions)  93. 99 39. 99  94. 00 39. 98  95. 10 39. 98  96. 20 163, 688 40. 00  97. 10 40. 00  97. 10 40. 00  97. 10 41. 00  97. 10 42. 00  97. 10 44. 00  97. 10 10 97. 00  97. 10 97. 00  97. 10 97. 00  97. 10 97. 00  97. 10 97. 00  97. 10 97. 00  97. 10 97. 00  97. 10 97. 00  97. 10 97. 00  97. 10 97. 00  97. 10 97. 00  97. 10 97. 00	39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			ļ	
39. 99   RECOVERY OF ACCELERATED DEPRECIATION   0   39. 99   40. 00   Subtotal (see instructions)   2, 163, 688   40. 00   40. 01   Sequestration adjustment (see instructions)   43, 274   40. 01   40. 02   40. 02   40. 02   40. 00   40. 02   40. 00   40	39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
40.00   Subtotal (see instructions)   2, 163, 688   40.00   40.01   Sequestration adjustment (see instructions)   43, 274   40.01   40.02   Demonstration payment adjustment amount after sequestration   0   40.02   41.00   Interim payments   2, 112, 446   41.00   42.00   Tentative settlement (for contractors use only)   2, 112, 446   43.00   Balance due provider/program (see instructions)   7, 968   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   Sil15.2   0   70   BE COMPLETED BY CONTRACTOR   0   90.00   Original outlier amount (see instructions)   0   90.00   91.00   Outlier reconciliation adjustment amount (see instructions)   0   91.00   92.00   The rate used to calculate the Time Value of Money (see instructions)   0   93.00	39. 98	Partial or full credits received from manufacturers for replaced	devices (see instruc	tions)	0	39. 98
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  80.00 Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Oggen Advanced	39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.02 Demonstration payment adjustment amount after sequestration  41.00 Interim payments  Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  5115.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  0 Untiler reconciliation adjustment amount (see instructions)  1 O 90.00  91.00 The rate used to calculate the Time Value of Money  Time Value of Money (see instructions)  0 40.02  41.00  42.00  42.00  43.00  7,968  43.00  44.00  90.00  91.00  92.00  93.00  Time Value of Money (see instructions)  0 90.00  93.00	40.00	Subtotal (see instructions)			2, 163, 688	40.00
41.00   Interim payments   2,112,446   41.00   42.00   43.00   Balance due provider/program (see instructions)   7,968   43.00   44.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   0   44.00   10   10   10   10   10   10   10	40. 01	Sequestration adjustment (see instructions)			43, 274	40. 01
42.00 Tentative settlement (for contractors use only)  43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 SI15.2 To BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  94.00 O 93.00	40. 02				0	40. 02
43.00 Balance due provider/program (see instructions)  44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 Si15.2 To BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  93.00 Og 10.00 Og 10					2, 112, 446	
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{5115.2}{10 BE COMPLETED BY CONTRACTOR}\$  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
\$115.2  TO BE COMPLETED BY CONTRACTOR  90.00 91.00 91.00 92.00 93.00 Time Value of Money (see instructions)  \$115.2  10 BE COMPLETED BY CONTRACTOR  90.00 91.00 91.00 92.00 93.00						
TO BE COMPLETED BY CONTRACTOR  90.00 91.00 91.00 92.00 The rate used to calculate the Time Value of Money Time Value of Money (see instructions)  To BE COMPLETED BY CONTRACTOR  90.00 91.00 91.00 92.00 93.00	44. 00		with CMS Pub. 15-2,	chapter 1,	01	44. 00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Time Value of Money (see instructions)  0 91.00  92.00  93.00	00.05					00.05
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00						
93.00 Time Value of Money (see instructions) 0 93.00		•				
		1				
74.00   Total (Suiii of Titles 71 and 73)		,				
	74. UU	Total (Sum of Titles 21 and 23)		I	U	74.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0064 Peri od: Worksheet E-1 From 10/01/2018 To 07/15/2019 Part I Date/Time Prepared: 12/18/2019 2:44 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy Amount mm/dd/yyyy Amount 4.00 1.00 2.00 3.00 1.00 Total interim payments paid to provider 1, 553, 366 2, 026, 841 1.00 Interim payments payable on individual bills, either 2 00 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 10/01/2018 85, 605 3.01 3.02 0 3.02 0 0 3 03 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 85, 605 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2, 112, 446 4.00 1, 553, 366 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after 5.00 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  $\,$ Program to Provider 5.01 TENTATI VE TO PROVI DER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 5.50 0 5.51 0 0 5. 51 5.52 0 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5. 50-5. 98)

293, 499

Contractor

Number

1.00

1, 846, 865

6.00

6.01

6.02

7.00

8 00

7, 968

2, 120, 414

NPR Date

(Mo/Day/Yr)

2.00

6.00

6.01

6.02

7.00

the cost report. (1)

SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Determined net settlement amount (balance due) based on

Total Medicare program liability (see instructions)

Provider CCN: 15-0064 Worksheet E-1 From 10/01/2018 To 07/15/2019 Part I Component CCN: 15-U064 Date/Time Prepared: 12/18/2019 2:44 pm Title XVIII Swing Beds - SNF PPS Inpatient Part A Part B mm/dd/yyyy Amount mm/dd/yyyy Amount 1.00 3.00 4.00 1.00 Total interim payments paid to provider 1.00 Interim payments payable on individual bills, either 2 00 0 2 00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. write "NONE" or enter a zero List separately each retroactive lump sum adjustment 3.00 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 3.01 0 3.02 0 3.02 0 3 03 0 3 03 3.04 0 0 3.04 0 3.05 3.05 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 0 3.51 3.51 0 0 3.52 3.52 3 53 0 0 3 53 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 0 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  $\,$ Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 0 0 5.02 0 5.02 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5. 50-5. 98) 6.00 6.00 Determined net settlement amount (balance due) based on

0

0

0

Contractor Number

1.00

0

0

0

NPR Date

(Mo/Day/Yr)

2.00

6.01

6.02

7.00

8.00

the cost report. (1)

SETTLEMENT TO PROVIDER

Total Medicare program liability (see instructions)

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

6.01

6.02

7.00

Heal th	Financial Systems FAYETTE REGIONAL H	EALTH SYSTEM	In Lie	u of Form CMS-2	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0064 From 10/01/2018 Part II To 07/15/2019 Date/Tir 12/18/20				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2. 00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt.					7.00
	line 168				
8.00	8.00 Calculation of the HIT incentive payment (see instructions)				
9.00	9.00 Sequestration adjustment amount (see instructions)				
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				
I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH					1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00
		, ,			

Health Financial Systems	FAYETTE REGIONAL HE	EALTH SYSTEM	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provi der CCN: 15-0064	Peri od: From 10/01/2018	Worksheet E-2	
		Component CCN: 15-U064	To 07/15/2019	Date/Time Prep 12/18/2019 2:	
		Title XVIII	Swing Beds - SNF	PPS	
			D+ A	D+ D	

		Title XVIII S	wing Beds - SNF	12/18/2019 2: PPS	тт рііі
		TI LI C XVIII	Part A	Part B	
			1.00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
. 00	Inpatient routine services - swing bed-SNF (see instructions)		0	0	1.0
. 00	Inpatient routine services - swing bed-NF (see instructions)				2.0
. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, a	·		0	3.0
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instruct				
. 00	Per diem cost for interns and residents not in approved teaching pr	ogram (see		0. 00	4.0
00	instructions)			0	
- 1	Program days	+! 000)	0	0	
1	Interns and residents not in approved teaching program (see instruction utilization review - physician compensation - SNF optional method of		0	U	7.0
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	iii y		0	
	Primary payer payments (see instructions)		0	0	
	Subtotal (line 8 minus line 9)		0	0	
- 1	Deductibles billed to program patients (exclude amounts applicable	to physician	0	0	1
	professional services)				
2.00	Subtotal (line 10 minus line 11)		0	0	12. (
3.00	Coinsurance billed to program patients (from provider records) (exc	lude coinsurance	0	0	13.0
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		0	0	
- 1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		_		16.
	Rural community hospital demonstration project (§410A Demonstration	) payment	0		16.
	adjustment (see instructions)			0	1,4
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
- 1	Allowable bad debts for dual eligible beneficiaries (see instructions)	ins)		0	ı
	Total (see instructions)	113)	0	0	ı
	Sequestration adjustment (see instructions)		0	0	
- 1	Demonstration payment adjustment amount after sequestration)		0	0	
- 1	Interim payments		o	0	1
- 1	Tentative settlement (for contractor use only)		0	0	21.
2.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21	)	0	0	22.
3.00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	0	0	23.
	chapter 1, §115.2				]
	Rural Community Hospital Demonstration Project (§410A Demonstration				
30. 00	Is this the first year of the current 5-year demonstration period u	nder the 21st			200.
	Century Cures Act? Enter "Y" for yes or "N" for no.				-
	Cost Reimbursement	D 1 D+ II I:			201
31.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. 66 (title XVIII hospital))	D-1, Pt. II, IIIle			201.
n2 nn	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst	D_3 col 3 line			202.
32.00	200 (title XVIII swing-bed SNF))	. D 3, COI. 3, TITIC			202.
03. 00	Total (sum of lines 201 and 202)				203.
	Medicare swing-bed SNF discharges (see instructions)				204.
	Computation of Demonstration Target Amount Limitation (N/A in first	year of the currer	t 5-year demons		
	peri od)		•		
05.00	Medicare swing-bed SNF target amount				205.
06. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times I				206.
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
	Program reimbursement under the §410A Demonstration (see instruction	,			207.
00 .80	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col	. 1, sum of lines 1			208.
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructions	<b>(a)</b>			209.
10. 00	Reserved for future use				210.
	Comparision of PPS versus Cost Reimbursement				215.
15 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 pl				

Health Financial Systems	FAYETTE REGIONAL HE	ALTH SYSTEM	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-0064	Peri od:	Worksheet E-2
		Component CCN: 15-U064	From 10/01/2018 To 07/15/2019	
				12/18/2019 2:44 pm
		Title XIX	Swing Reds - SNE	DDS

				12/18/2019 2:	44 pm
		Title XIX S	wing Beds - SNF	PPS	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES		.1		
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		0		2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		0		3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
4. 00	Per diem cost for interns and residents not in approved teachi	ng program (see	0. 00		4. 00
F 00	instructions)				F 00
5.00	Program days	-+	0		5.00
6. 00	Interns and residents not in approved teaching program (see in		0		6.00
7.00	Utilization review - physician compensation - SNF optional met	nod oni y	0		7.00
8. 00 9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		0		8. 00 9. 00
10.00	Subtotal (line 8 minus line 9)		0		10.00
11. 00	, ,	able to physician	0		11.00
11.00	Deductibles billed to program patients (exclude amounts applic professional services)	able to physician	U U		111.00
12. 00	Subtotal (line 10 minus line 11)		0		12.00
13. 00	Coinsurance billed to program patients (from provider records)	(evolude coi nsurance	0		13.00
13.00	for physician professional services)	(exertade corrisar ance			13.00
14. 00	80% of Part B costs (line 12 x 80%)		0		14.00
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	0		15.00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•,	0		16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	)			16.50
16. 55	Rural community hospital demonstration project (§410A Demonstr				16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0		16. 99
17.00	Allowable bad debts (see instructions)		0		17.00
17. 01	Adjusted reimbursable bad debts (see instructions)		0		17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	0		18.00
19.00	Total (see instructions)		0		19.00
19. 01	Sequestration adjustment (see instructions)		0		19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0		19. 02
20.00	Interim payments		0		20.00
21.00	Tentative settlement (for contractor use only)		0		21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, a	nd 21)	0		22. 00
23.00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	0		23. 00
	chapter 1, §115.2				_
	Rural Community Hospital Demonstration Project (§410A Demonstr				
200.00	Is this the first year of the current 5-year demonstration per	iod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				1
	Cost Reimbursement		T		4
201.00	Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201. 00
202.00	66 (title XVIII hospital))	Wi-+ D 2! 2 !:			202 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	WKSt. D-3, COL. 3, TIME			202.00
202 00	200 (title XVIII swing-bed SNF)) Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				203.00
204.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the surren	t 5 year demons	tration	204.00
	period)	irrst year or the curren	t 5-year deliloris	tration	
205.00	Medicare swing-bed SNF target amount		I		205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206.00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				200.00
207 00	Program reimbursement under the §410A Demonstration (see instr		I		207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	•			208.00
200.00	and 3)	, 601. 1, 34 01 111163 1			200.00
209 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209. 00
	Reserved for future use	<del>- /</del>			210.00
	Comparision of PPS versus Cost Reimbursement				1
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215. 00
	instructions)				
			•		-

Health Financial Systems	FAYETTE REGIONAL HEALTH SYSTEM	In Li eu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0064	From 10/01/2018 To 07/15/2019	Worksheet E-3 Part VII Date/Time Prepared: 12/18/2019 2:44 pm

PART_VII - CALCULATION OF RELINDERSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				lo 07/15/2019	Date/lime Pre   12/18/2019 2:	
PART VII - CALCULATION OF RETINDURSHAPT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal		тт рііі
PART VII - CALCULATION OF RETINDURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			THE ALX			
PART VI   - CALCULATION OF REINBURSIMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.00   1.00   Interest hospital SNE/NE services   744, 906   1.00   2.00   3.00   0.00   an acquisist ton (certified transplant centers only)   0   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.00   3.00   0.		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR XI		2.00	
Inpati ent hospital /SIFAFA services			VIOLO FOR TITLES V OR XI	X OLIVI OLO		
Medical and other services   0   2.00	1 00			744 906		1 00
1.00   Organ acquisition (certified transplant centers only)				744, 700	0	
3.00   Subtratal (sum of lines 1, 2 and 3)   744,906   0   4.00   0   6.00   0   0   0   0   0   0   0   0   0					U	
Inpati ent primary payer payments				_	0	
0.00   Outpatient primary payer payments		1		744, 700	U	
Subtotal (line 4 less sum of lines 5 and 6)				١	0	
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable Charges   138,850   8.00   Routine service charges   1,051,148   0.90, 00   Ancil lary service charges, net of revenue   1,051,148   0.90, 01,000   0.00   0				744 004		
Reasonable Charges   1.38,850   8.00   Ancillary service charges   1.051,148   0   9.00   10.00   Incentive From target amount computation   0   11.00   Incentive From target amount computation   0   12.00   Incentive From target amount computation   0   Incentive From target amount computatio	7.00			744, 900	U	7.00
Routine service charges   138,850   8.00   1.051,148   0.9						
9.00   Ancillary service charges   1,051,148   0   9.00     10.00   Incentive from target amount computation   10.00     10.00   Incentive from target amount computation   10.00     10.00   Incentive from target amount computation   1.00     10.00   Incentive from target sold from patients liable for payment for services on a charge basis   1.00     10.00   Incentive from target amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e)   1.00     10.00   Incentive from target amounts that would have been realized from patients liable for payment for services on   0   0   0.00000     10.00   Incentive from target amounts amounts amounts are services on   0   0   0.000000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.000000   0.00000000	0.00			120.050		0 00
10.00   Organ acquisition charges, net of revenue   0   10.00   11.00   17.0		, and the second			0	
11.00   Incentive from target amount computation   1.189, 998   0   12.00   CUSTOWARY CHARGES   13.00   Amount actually collected from patients liable for payment for services on a charge basis   14.00   Amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.00000   0.000000   15.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   0.000000   15.00   Ratio of line 13 to line 14 (not to exceed 1.000000)   0.000000   15.00   17.00   Excess of customary charges (see instructions)   1.189, 998   0.16.00   16.00   Total customary charges (see instructions)   1.189, 998   0.16.00   16.00   16.00   Total customary charges over reasonable cost (complete only if line 16 exceeds   445,092   0.17.00   16					Ü	
12.00   Total reasonable charges (sum of lines 8 through 11)   1,189,998   0   12.00				0		
CUSTOMARY CHARGES				1 100 000	0	
13.00   Amount actually collected from patients liable for payment for services on a charge basis	12.00			1, 189, 998	0	12.00
basis	40.00		<del></del>	1 0		40.00
14.0   Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)   0.000000   0.000000   15.00   16.00   17.01   18.01   18.00   17.01   18.00   17.00	13.00		services on a charge	0	0	13.00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e)  Ratio of line 13 to line 14 (not to exceed 1.000000)  16.00 Total customary charges (see instructions)  17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds	44.00					
15.00   Ratio of Fline 13 to line 14 (not to exceed 1.000000)   15.00   Total customary charges (see instructions)   1.189,998   0   16.00   17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   445,092   0   17.00   18.00   18.00   Excess of customary charges over reasonable cost (complete only if line 4 exceeds line   0   0   18.00   16.	14.00				0	14.00
16.00   Total customary charges (see instructions)   1, 189,998   17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   11.00   17.00	45.00		2 CFR §413.13(e)			45.00
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   11.00		,				
			1611 17		_	
18.00   Excess or reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   0   0   18.00   19.00   10   10   10   10   10   10   10	17.00		y if line 16 exceeds	445, 092	0	17.00
16) (see instructions)	40.00		1611 4		0	40.00
19.00   Interns and Residents' (see instructions)   0   0   19.00   20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   0   20.00	18.00		y it line 4 exceeds line		0	18.00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   0   20.00     21.00   Cost of covered services (enter the lesser of line 4 or line 16)   744, 906   0   21.00     PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.     22.00   Other than outlier payments   0   0   22.00     23.00   Outlier payments   0   0   23.00     24.00   Program capital payments   0   0   24.00     25.00   Capital exception payments (see instructions)   0   0   24.00     26.00   Routine and Ancillary service other pass through costs   0   0   27.00     28.00   Customary charges (title V or XIX PPS covered services only)   0   0   27.00     29.00   Outlies V or XIX (sum of lines 21 and 27)   744, 906   0   29.00     20.00   Outlies V or XIX (sum of lines 11 and 27)   744, 906   0   31.00     31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   744, 906   0   32.00     32.00   Deductibles   0   0   32.00     33.00   Coinsurance   0   0   32.00     34.00   Allowable bad debts (see instructions)   0   0   32.00     35.00   Utilization review   0   0   34.00     36.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   744, 906   0   36.00     37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00     38.00   Subtotal (line 36 ± line 37)   744, 906   0   38.00     39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00     40.00   Total amount payable to the provider (sum of lines 38 and 39)   744, 906   0   40.00     40.00   Total amount payable to the provider (sum of lines 38 and 39)   744, 906   0   40.00     40.00   Interim payments   0   42.00     40.00   Outlier payments   0   42.00     40.00   Interim payments   0   42.00     40.00   Outlier	40.00				0	10.00
21.00   Cost of covered services (enter the lesser of line 4 or line 16)   744, 906   0   21.00				- Y	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.   22.00   Other than outlier payments   0   0   23.00   Outlier payments   0   0   25.00   Outlier payments (see instructions)   0   0   25.00   Outlier and Ancillary service other pass through costs   0   0   0   26.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   27.00   Outlier and Ancillary service other pass through costs   0   0   0   0   0   0   0   0   0				-	-	
22. 00       Other than outlier payments       0       0       22. 00         23. 00       Outlier payments       0       0       23. 00         24. 00       Program capital payments       0       24. 00         25. 00       Capital exception payments (see instructions)       0       25. 00         26. 00       Routine and Ancillary service other pass through costs       0       0       26. 00         27. 00       Subtotal (sum of lines 22 through 26)       0       0       27. 00         28. 00       Customary charges (title V or XIX PPS covered services only)       0       0       28. 00         29. 00       Titles V or XIX (sum of lines 21 and 27)       744, 906       0       29. 00         20. 00       Excess of reasonable cost (from line 18)       0       0       30. 00         31. 00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       744, 906       0       31. 00         32. 00       Deductibles       0       0       33. 00         33. 00       Coinsurance       0       0       33. 00         34. 00       Allowable bad debts (see instructions)       0       0       34. 00         35. 00       Utilization review       0       35. 00 <t< td=""><td>21.00</td><td></td><td></td><td></td><td>0</td><td>21.00</td></t<>	21.00				0	21.00
23. 00 Outlier payments			completed for PPS provid			
24.00 Program capital payments 25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 Excess of reasonable cost (from line 18) 30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 31.00 Oli Ilization review 32.00 Allowable bad debts (see instructions) 33.00 Oli Free ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 33.00 Oli Free ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 34.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 Direct may be a subtoral (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 42.00 Bal ance due provider/program (line 40 minus line 41) 42.00 Bal ance due provider/program (line 40 minus line 41) 42.00 Bal ance due provider/program (line 40 minus line 41)		1 3				
25. 00 Capital exception payments (see instructions) 26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Tomputation of Reimbursement Settlement  30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Interim payments 42. 00 Bal ance due provider/program (line 40 minus line 41) 42. 00 Bal ance due provider/program (line 40 minus line 41)				_	0	
26. 00 Routine and Ancillary service other pass through costs 27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 42. 00 Balance due provider/program (line 40 minus line 41) 42. 00				_		
27. 00 Subtotal (sum of lines 22 through 26) 28. 00 Customary charges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 42. 00 Balance due provider/program (line 40 minus line 41)				٩		
28. 00 Customary charges (title V or XIX PPS covered services only)  7		, ,		٩	-	
29. 00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41)  744, 906 0 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20 20 20 20 20 20 20 20 21 21 22 24 25 26 27 27 24 25 26 27 27 24 27 28 29 29 20 29 20 20 20 21 21 22 22 23 24 24 20 24 20 29 20 20 20 20 20 21 21 22 22 23 24 24 20 24 20 25 26 26 27 27 24 24 20 27 28 29 20 20 20 20 20 20 20 20 20 20 20 20 20		,		Ĭ	-	
COMPUTATION OF REIMBURSEMENT SETTLEMENT   30.00   Excess of reasonable cost (from line 18)   31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   744,906   0   31.00   32.00   32.00   Deductibles   0   0   0   32.00   33.00   Coin surance   0   0   0   34.00   34.00   Allowable bad debts (see instructions)   0   0   0   34.00   35.00   Utilization review   0   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   744,906   0   36.00   37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00   38.00   Subtotal (line 36 ± line 37)   744,906   0   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00   40.00   Total amount payable to the provider (sum of lines 38 and 39)   744,906   0   40.00   41.00   Interim payments   599,482   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   145,424   0   42.00				١		
30.00   Excess of reasonable cost (from line 18)	29.00			/44, 906	0	29.00
31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32. 00 Deductibles  33. 00 Coi nsurance  34. 00 Allowable bad debts (see instructions)  35. 00 Utilization review  36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38. 00 Subtotal (line 36 ± line 37)  39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Interim payments  42. 00 Balance due provider/program (line 40 minus line 41)  744, 906  0 31. 00  0 32. 00  0 32. 00  0 33. 00  0 34. 00  0 34. 00  0 35. 00  0 36. 00  37. 00  0 38. 00  0 39. 00  0 40. 00  41. 00  42. 00  42. 00				1 0		
32.00   Deductibles   0   32.00   33.00   33.00   33.00   34.00   34.00   34.00   34.00   35.00   Utilization review   0   35.00   35.				_	-	
33.00   Coinsurance   0   0   33.00   34.00   34.00   Allowable bad debts (see instructions)   0   0   34.00   35.00   Utilization review   0   35.00   35.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   744,906   0   36.00   37.00   37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00   38.00   39.00   Direct graduate medical education payments (from Wkst. E-4)   0   0   39.00   OTOTAL amount payable to the provider (sum of lines 38 and 39)   744,906   0   40.00   41.00   Interim payments   599,482   0   41.00   42.00   Balance due provider/program (line 40 minus line 41)   145,424   0   42.00		,			_	
34.00       Allowable bad debts (see instructions)       0       34.00         35.00       Utilization review       0       35.00         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       744,906       0       36.00         37.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       0       37.00         38.00       Subtotal (line 36 ± line 37)       744,906       0       38.00         39.00       Direct graduate medical education payments (from Wkst. E-4)       0       39.00       744,906       0       49.00         41.00       Interim payments       599,482       0       41.00         42.00       Balance due provider/program (line 40 minus line 41)       145,424       0       42.00				٩	_	
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.44,906 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41)  0 35.00 35.00 36.00 37.00 37.00 37.00 37.00 37.00 37.00 37.00 39.00 41.00 41.00 42.00				0	-	
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  744,906  0 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  744,906  0 37.00  744,906  0 38.00  39.00  10 pirect graduate medical education payments (from Wkst. E-4)  10 Total amount payable to the provider (sum of lines 38 and 39)  11 payments  12 payments  13 payments  14 pos payments  15 payments  16 payments  17 payments  17 payments  17 payments  18 payments  18 payments  19 payments  19 payments  10 payments  10 payments  10 payments  10 payments  11 payments  12 payments  13 payments  14 payments  15 payments  16 payments  17 payments  17 payments  17 payments  17 payments  18 payments  18 payments  18 payments  18 payments  18 payments  18 payments  19 payments  19 payments  19 payments  19 payments  10 payments				0	0	
37.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       37.00         38.00       Subtotal (line 36 ± line 37)       744,906       0         39.00       Direct graduate medical education payments (from Wkst. E-4)       0       39.00         40.00       Total amount payable to the provider (sum of lines 38 and 39)       744,906       0       40.00         41.00       Interim payments       599,482       0       41.00         42.00       Balance due provider/program (line 40 minus line 41)       145,424       0       42.00				0		
38.00       Subtotal (line 36 ± line 37)       744,906       0       38.00         39.00       Direct graduate medical education payments (from Wkst. E-4)       0       39.00         40.00       Total amount payable to the provider (sum of lines 38 and 39)       744,906       0       40.00         41.00       Interim payments       599,482       0       41.00         42.00       Balance due provider/program (line 40 minus line 41)       145,424       0       42.00			33)	744, 906		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 39.00 40.00 41.00 42.00				0	-	37.00
40.00       Total amount payable to the provider (sum of lines 38 and 39)       744,906       0 40.00         41.00       Interim payments       599,482       0 41.00         42.00       Balance due provider/program (line 40 minus line 41)       145,424       0 42.00		,		744, 906	0	38. 00
41.00 Interim payments 599,482 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 145,424 0 42.00				0		39.00
42.00 Balance due provider/program (line 40 minus line 41) 145,424 0 42.00		, , ,			_	40.00
					_	
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2.	42.00			145, 424		42.00
9 19191	43.00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43.00
chapter 1, §115.2		chapter 1, §115.2				

Health Financial Systems FAYETTE REGION
BALANCE SHEET (If you are nonproprietary and do not maintain
fund-type accounting records, complete the General Fund column
only)

Provider CCN: 15-0064

Peri od: Worksheet G From 10/01/2018 To 07/15/2019 Date/Time Prepared: 12/18/2019 2: 44 pm

OIII y)					12/18/2019 2:	44 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS					
1. 00	Cash on hand in banks	496, 592	1	0	0	
2.00	Temporary investments	0	0	0	_	1
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	0 740 050	0	0	0 0	
5. 00	Other receivable	9, 769, 858 4, 063, 141		0	0	
6. 00	Allowances for uncollectible notes and accounts receivable			0	0	
7. 00	Inventory	758, 274	Ō	0	0	
8.00	Prepai d expenses	996, 437	0	0	0	
9. 00	Other current assets	0	0	0	0	
10.00	Due from other funds	0	0	0	0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	16, 084, 302	0	0	0	11.00
12. 00	Land	1, 495, 800	O	0	0	12.00
13. 00	Land improvements	1, 473, 660		0	1	
14. 00	Accumulated depreciation	0	Ö	0	•	
15.00	Bui I di ngs	60, 126, 946	0	0	0	15.00
16. 00	Accumulated depreciation	-55, 955, 093	0	0	0	1
17. 00	Leasehold improvements	0	0	0	0	1
18.00	Accumulated depreciation	0	0	0	0	
19. 00 20. 00	Fixed equipment Accumulated depreciation	0	0	0	0	1
21. 00	Automobiles and trucks			0	0	
22. 00	Accumulated depreciation		0	0	0	1
23. 00	Major movable equipment	19, 337, 525		0	Ö	
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Mi nor equi pment depreciable	0	0	0	0	
26. 00	Accumulated depreciation	0	0	0	0	1
27. 00	HIT designated Assets	0	0	0	0	
28. 00	Accumulated depreciation	0	0	0	0	
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	25, 005, 178	0	0	0	
30.00	OTHER ASSETS	25,005,176	ıj U	0	0	30.00
31. 00	Investments	225, 187	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33. 00	Due from owners/officers	11, 154	0	0	0	
34.00	Other assets	0	0	0	0	1
35. 00	Total other assets (sum of lines 31-34)	236, 341	0	0	0	
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	41, 325, 821	0	0	0	36.00
37. 00	Accounts payable	Ι ο	ol	0	0	37.00
38. 00	Salaries, wages, and fees payable	485, 890		0		1
39. 00	Payrol I taxes payable	645, 003	1	0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	
41. 00	Deferred income	0	0	0	0	
42.00	Accel erated payments	0				42.00
43. 00 44. 00	Due to other funds Other current liabilities	20, 197, 736		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	21, 328, 629		0		
43.00	LONG TERM LIABILITIES	21, 320, 027	٩			43.00
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0	0	0	0	47.00
48. 00	Unsecured Loans	0	0	0	_	1
49. 00	Other long term liabilities	15, 222, 899	1	0	_	
50.00	Total long term liabilities (sum of lines 46 thru 49)	15, 222, 899	1	0		
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	36, 551, 528	0	0	0	51.00
52. 00	General fund balance	4, 774, 293				52.00
53.00	Specific purpose fund	1, 7, 1, 2,0	O			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	4, 774, 293		0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	41, 325, 821	1	0	Ö	
	59)			· ·		
			,			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-0064

					То	07/15/2019	Date/Time Pre 12/18/2019 2:	
		General	Fund	Speci al	Purp	oose Fund	Endowment Fund	
		1. 00	2.00	3. 00		4. 00	5. 00	
1. 00 2. 00 3. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	1.00	10, 356, 937 -5, 582, 644 4, 774, 293			0	3.00	1. 00 2. 00 3. 00
4. 00 5. 00 6. 00 7. 00	Additions (credit adjustments) (specify)	0 0 0	1, 17 1, 273		0 0 0	J	0 0 0	4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00	Total additions (sum of line 4-9)	0	0		0	0	0	8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0	4, 774, 293		0 0 0 0	0	0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 4, 774, 293		0	O O	0	17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0			1. 00 2. 00 3. 00 4. 00
5. 00 6. 00 7. 00 8. 00 9. 00			0 0					5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0		0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			18. 00 19. 00

Health Financial Systems FAYE STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0064

			0 0//15/2019	Date/IIme Pre 12/18/2019 2:	
	Cost Center Description	Inpatient	Outpati ent	Total	
		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	7, 044, 630		7, 044, 630	1.00
2.00	SUBPROVI DER - I PF	(		0	2.00
3.00	SUBPROVI DER - I RF	(		0	3.00
4.00	SUBPROVI DER	(		0	4.00
5.00	Swing bed - SNF			0	5.00
6.00	Swing bed - NF			0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	7, 044, 630	)	7, 044, 630	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	1, 537, 181		1, 537, 181	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	1, 537, 181		1, 537, 181	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	8, 581, 811		8, 581, 811	17.00
18. 00	Ancillary services	3, 621, 748		33, 563, 292	18. 00
19. 00	Outpati ent servi ces		,,	17, 005, 404	19.00
20. 00	RURAL HEALTH CLINIC		-	0	20.00
	FEDERALLY QUALIFIED HEALTH CENTER		0	0	
22. 00	HOME HEALTH AGENCY		0	0	22.00
23. 00	AMBULANCE SERVICES		0	0	23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE		0	0	26. 00
27. 00	EMPLOY BENE, DIETARY, OTHER NONREIMB	6, 246, 745		8, 160, 579	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	18, 450, 304	48, 860, 782	67, 311, 086	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		24 421 410		1 20 00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		34, 431, 419		29.00
30.00	ADD (SPECIFY)	(			30.00
31.00					31.00
32.00			1		32.00
33.00					33.00
34. 00 35. 00					34. 00 35. 00
	Total additions (sum of lines 20 25)				
36.00	Total additions (sum of lines 30-35)		0		36.00
37. 00	DEDUCT (SPECIFY)	`	1		37.00
38. 00 39. 00					38.00
					39.00
40. 00 41. 00					40. 00 41. 00
	Total deductions (sum of lines 27 41)		ή		41.00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transf	ior	34, 431, 419		42.00
43.00	to Wkst. G-3, line 4)	CI	34, 431, 419		43.00
	10 m/st. 0-3, 11116 4)	1			I

Health Financial Systems FAYETTE REGIONAL HEALTH SYSTEM In Lie	eu of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-0064 Period:	Worksheet G-3	
From 10/01/2018 To 07/15/2019		
	1. 00	
1.00   Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	67, 311, 086	1.00
2.00 Less contractual allowances and discounts on patients' accounts	39, 590, 781	2.00
3.00 Net patient revenues (line 1 minus line 2)	27, 720, 305	3.00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	34, 431, 419	•
5.00 Net income from service to patients (line 3 minus line 4)	-6, 711, 114	5.00
OTHER I NCOME		, ,,
6.00   Contributions, donations, bequests, etc	0	6.00
7.00   Income from investments	0	7.00
8.00 Revenues from telephone and other miscellaneous communication services	0	8.00
9.00 Revenue from television and radio service	0	9.00
10.00 Purchase discounts	0	1
11.00 Rebates and refunds of expenses	0	1
12.00 Parking Lot receipts	0	
13.00 Revenue from Laundry and Linen service	0	
14.00 Revenue from meals sold to employees and guests	0	
15.00 Revenue from rental of living quarters	0	
16.00 Revenue from sale of medical and surgical supplies to other than patients	0	
17.00 Revenue from sale of drugs to other than patients		17.00
18.00 Revenue from sale of medical records and abstracts	0	
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0	
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00 Rental of vending machines	0	21.00
22.00 Rental of hospital space	0	22.00
23.00 Governmental appropriations	0	23.00
24. 00 OTHER OPER REV, NONOP REV MISC	1, 128, 780	
25.00 Total other income (sum of lines 6-24)	1, 128, 780	1
26.00 Total (line 5 plus line 25)	-5, 582, 334	l .
27. 00 ROUNDING		27.00

310 28.00 -5, 582, 644 29.00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

	<del></del>	AL HEALTH SYSTEM		u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0064	Peri od: From 10/01/2018 To 07/15/2019	Worksheet L Parts I-III Date/Time Pre 12/18/2019 2:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			78, 387	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			873	2.00
2. 01	Model 4 BPCI Capital DRG outlier payments		<b></b>	0	
3. 00 4. 00	Total inpatient days divided by number of days in the cos Number of interns & residents (see instructions)	st reporting period (see ins	tructions)	12. 38 0. 00	
5. 00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by	0.00	ı		
	1. 01) (see instructions)	,	.,	_	
7.00	Percentage of SSI recipient patient days to Medicare Part	t A patient days (Worksheet	E, part A line	0. 00	7.00
	30) (see instructions)			0.00	
8.00	Percentage of Medicaid patient days to total days (see in	nstructions)		0.00	
9. 00 10. 00				0. 00 0. 00	
11. 00	, , , , , , , , , , , , , , , , , , , ,			0.00	11.00
12. 00					12.00
12:00	process processors to eaps tar payments (coe river dott one)			777200	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)			0	
2. 00	Program inpatient ancillary capital cost (see instruction			0	
4. 00					
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
	The same of the sa			-	
	DADT LLL COMPUTATION OF EVOEDTION DAVMENTS			1. 00	
1. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	l 1.00
2. 00	Program inpatient capital costs (see instructions)	stances (see instructions)		0	
3. 00	Net program inpatient capital costs for extraordinary circumstances (see instructions)			0	
4. 00	Appli cable exception percentage (see instructions)			0. 00	
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5.00
6.00	Percentage adjustment for extraordinary circumstances (se	ee instructions)		0. 00	6.00
7.00	Adjustment to capital minimum payment level for extraordi	nary circumstances (line 2	x line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as a		1	0	
10. 00 11. 00	Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level on			0	
11.00	Worksheet L, Part III, line 14)	ver capital payment (110m pr	i oi yeai	U	11.00
		al payments (line 10 plus li	ne 11)	0	12.00
12. 00	Current year exception payment (if line 12 is positive, e			0	
12. 00 13. 00				0	
	Carryover of accumulated capital minimum payment level ov	er capitai payment for the	. o og po ou i	•	
13.00	Carryover of accumulated capital minimum payment level on (if line 12 is negative, enter the amount on this line)	1 1 3	land and the second		
13. 00 14. 00 15. 00	Carryover of accumulated capital minimum payment level on (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	e instructions)	remaining permua	0	
13. 00 14. 00 15. 00 16. 00	Carryover of accumulated capital minimum payment level on (if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see	e instructions)		0	